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ABSTRACT

The World Bank helps countries to arrive at whatever combination of public and private control is best for their particular economic circumstances. This booklet describes that work and summarizes examples of private-sector involvement in health and education provision in the developing world today. The examples also illustrate what the World Bank is doing to help bring those outside government-communities, nongovernmental organizations (NGOs), private voluntary organizations, private providers, and corporations--into the design and implementation of social-service projects. Part 1 describes the historical roots of present trends--the development of modern health care systems, mass education systems--and the inequities that currently exist in health and education. The role of the World Bank in eliminating the social deficit and reducing poverty worldwide is described. The World Bank advocates using competitive markets to organize the production and distribution of goods and services and using a market-oriented approach to development. Part 2 offers examples of World Bank assistance in Kenya, Pakistan, Bolivia, India, Columbia, Burkino Faso, Mexico, Panama, Peru, Uruguay, Estonia, and Brazil. Sixteen boxes, 5 figures, and 2 tables are included. (Contains 63 references.) (LMI)

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DIRECTIONS IN DEVELOPMENT

Private and Public Initiatives

Working Together for Health and Education

JACQUES VAN DER GAAG

U.S. DEPARTMENT OF EDUCATION
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Working Together for Health and Education

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Foreword

Never before have so many people worldwide aspired to so large an improvement in their standard of living. And never before has the possibility of achieving their goals been so close within reach. Both the challenges and the opportunities beckon us onward.

The challenges include, first, the fact that a billion people—a fifth of the world's population—live on less than a dollar a day, and many others remain far below the decent quality of life they have a right to expect in a world with so much plenty. More progress has been achieved in raising living standards in the last fifty years than at any other time in human history, but much more progress is still needed. Also, much remains to be done to empower people more, especially people who in the past have been denied a fair place in decisionmaking.

The opportunities are no less substantial. Much has been learned in recent years about how to help people solve problems and improve their circumstances. This new knowledge—a potent addition to the planet's most potent resource, its human capital—now needs to applied more systematically.

One key advance has been a better understanding of the importance of and interconnections among two essential prerequisites for development: (1) a thriving, growing economy and public policies that make that possible, and (2) investment in people through education, health, and other basic services. A thriving economy is vital for generating the jobs, earnings, and expanding opportunities, for example, for smaller farmers and microenterprises. Investment in people is crucial for ensuring that families have the skills, health, and attitudes needed for taking advantage of the new opportunities that a healthy economy creates. The two reinforce each other: economic growth generates the added resources required for investing more in people, and investing in people provides the added humanpower, reflected in higher productivity, required for more economic development. The result is a "virtuous circle" that may well be the only way for some to escape the vicious circle of persistent poverty passed on from one generation to the next. East Asia has been the most dazzling example of this successful process so far. Others are poised to follow.

A second key advance has been the new insight on the relative roles of the public and the private sectors. Both have critical parts to play in facilitating development. In health and education, the responsibility of gov-

ernment in setting appropriate policies is particularly important, given the public interest in ensuring appropriate investments in people. Private entities—whether non-governmental organizations, community-based groups, or for-profit ventures—also can and do make major contributions through direct provision of services. Indeed, for eons until about a hundred years ago, private providers were the only source of health care and education, and even today they often account for a larger share of spending than do public sources. The government's role expanded for much of the current century, but is now being widely rethought in the wake of disappointing results both in the social sectors and more broadly.

Many developing countries' policies today strive for far more public-sector dominated and more centrally controlled health and education systems than exist in even the most "socialized" of OECD countries (or, in some cases, than in the case of the former socialist countries). Yet they get worse results. For example, a number of countries try to have central ministries of health or education manage the detailed affairs of clinics or schools throughout the country, even down to ordering medicines and books for each. No organization, public or private, can be effective and efficient if decisions are overcentralized.

The main public/private issues for most countries now in health and education are more subtle than the stark extremes portrayed in ideological debates. For example, some governments that are trying to be the sole or dominant provider should consider removing the barriers to greater development of private providers. Or for some services, they should continue as financier but gradually let others take over as the actual providers of those services. Or they should take advantage of new ways of encouraging constructive competition—within the context of policies and regulations that prevent abuses.

On all this, the World Bank is giving high priority to helping countries respond to the challenges and opportunities before them. The Bank's lending for education, health, nutrition, population, and other aspects of human capital development has increased sharply in recent years—tripling since the early 1980s—and is now averaging over $3 billion a year. Substantially more Bank financing goes to these areas than to support for economic reform programs. Also, the Bank has intensified its support for primary services (basic schooling and health), where the benefits for economic growth and poverty reduction are the greatest. It has increased its emphasis as well on education for girls, women's reproductive health, nutrition, and early childhood development. In addition to its lending, the Bank has expanded its other ways of helping—through policy advice, technical assistance, donor collaboration, poverty assessments, and more. Along with this focus on investing in people, the Bank also assists countries to establish and maintain economic policies for a thriving, growing economy. Ensuring macroeconomic stability, an open economy, access to world markets, the right structure of incentives, and the proper functioning of capital and labor markets are critical for making investments in

human capital more productive. The quality of investment is as important as the quantity—if not more so.

As part of these efforts, the Bank assists countries to arrive at whatever form of public/private mix is best for their particular circumstances. This short booklet describes that work—with two main purposes. The first is to help redress an information gap. Many decisionmakers and others involved in choices about public/private roles have limited information on, or experience with, the diversity and subtleties of issues and possible solutions on what private entities can and do contribute in the health and education fields. The public side they may know well, but the private possibilities much less so. The examples presented here of different approaches from different countries and situations are meant to help correct that informational imbalance.

The second purpose is to bring together recent instances of the Bank's support for health and education initiatives involving the private sector, including some where non-governmental organizations and community-based groups have played an important role. A cross-section from various regions and subsectors of human development projects, these cases indicate the breadth and new directions of strategies now emerging. Some are still in their early stages, others more advanced. Additional cases, not discussed here because they are not far enough along yet, will soon be testing out still further ideas.

Ultimately, public/private choices are about finding practical solutions to practical problems. And since the problems and the factors surrounding them are constantly changing, the solutions must be constantly revisited too. The Bank is helping countries grapple with this process of change.

Armeane M. Choksi
Vice President
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PART 1

Private and Public Initiatives

Working Together for Health and Education

Private and Public Initiatives: Working Together for Health and Education

Changing Roles in a Changing World

Throughout most of recorded history people have gone to private teachers and private schools to get an education and to private doctors and hospitals when they were ill. Only in the twentieth century have governments—first in Europe and later in other regions of the world—become important providers of social services, in extreme cases excluding the private sector altogether.

Today's governments must strive to achieve the most productive balance of the private and public sector in social service provision. Yet all too often the officials who make these decisions are well-informed about public sector options (through innumerable reports, conferences, and their own experience) but know relatively little about what the private sector has to offer. Most are unaware that over the ages and around the world, private providers have developed a rich variety of strategies for delivering education, nutrition, health, and population services.

In an effort to help even the score, this booklet brings together examples of private sector involvement in social service provision in the developing world today. Clearly, no single balance of public and private service provision can be said to be ideal. Much has been written about all this.[1] But needs change with circumstances and over time, from city to countryside, and for different populations and geographical locations. The examples collected here are practical illustrations of social service partnerships between governments and the private sector that have worked.

These examples also illustrate what the World Bank is doing to help bring those outside government—communities, nongovernmental organizations (NGOs), private voluntary organizations, private providers and corporations—into the design and implementation of social service projects. A growing number of projects, for example, put resources for investment in schools, clinics, or other social projects directly into the hand of communities by establishing special social-investment funds. Project-funded school vouchers and health cards put resources directly into the hands of families. Beneficiaries are then free to use these funds to purchase services from the public sector, nonprofit private institutions, or for-profit private providers as they choose.

Although many Bank-supported initiatives involving the private sector in social service provision are too recent to be evaluated fully, they appear to be working well. And the continued success of joint public-private initiatives will strengthen public sector efficiency and increase private sector involvement. Looking to the future, the number of projects in health and education that rely on private resourcefulness can only be expected to grow.

Important Developments of Recent Decades

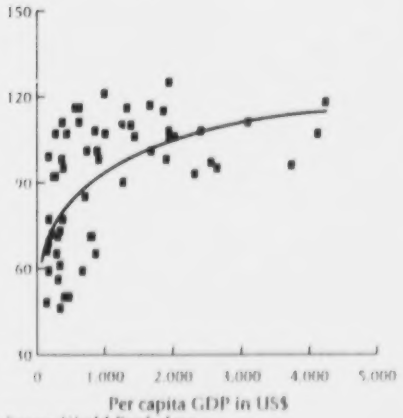
Progress—Substantial but Uneven

The past four decades have seen unprecedented progress in health and education in developing countries. In 1950 life-expectancy at birth was forty years; today it is sixty-two. Four decades ago, twenty-eight out of every 100 children died before the age of five; by 1990 this number had fallen to ten. In 1965 primary school enrollment ranged from 37.6 percent in low-income countries (excluding China and India) to 94.7 percent in high-income developing countries; by 1990 70 percent of children in low-income countries were enrolled in school, despite rapid population growth.

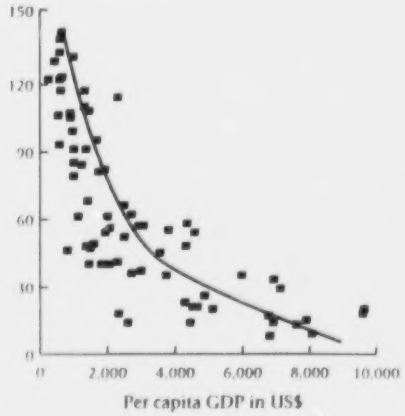
Much of this progress is associated with economic growth and the resulting improvement in living conditions (figure 1). Rising incomes helped generate the resources needed to expand and upgrade services, and stimulated families to demand better access to services of better quality.

Figure 1 Relation between income and primary school enrollment and infant mortality

Primary school enrollment and per capita GDP in selected developing countries, 1990



Infant mortality rate and per capita GDP in selected developing countries, 1992



Source: World Bank data.

Improvements in food supply, sanitation, water, and other determinants of living conditions also were accelerated by economic development.

But despite tremendous progress recorded on average, many countries—and within countries, many population groups—failed to benefit. Every year more than 11 million children die from preventable diseases, about 400,000 women die from direct complications from pregnancy and childbirth, and 130 million children do not attend primary school—a majority of them girls.

It is of the greatest urgency that social deficits in the developing world be eliminated. The suffering associated with excess disease and premature death is particularly intolerable given that there are effective and affordable measures to reduce this suffering. Any strategy to further the development of a country should therefore include substantial investment in its people.

The Vital Link between Social and Economic Development

In *World Development Report 1990*, the World Bank concludes that rapid and sustainable progress on poverty has been achieved in countries whose development policies have two equally important elements. First, they promote the productive use of the poor's most abundant asset—labor—to achieve broad-based economic growth. Second, they provide basic social services: primary health care, family planning and nutrition services, and primary education.

Also in 1990, the United Nations Development Programme published its first *Human Development Report*. That study points out the fallacy of the view that human development can only be promoted at the cost of economic growth. It stresses, rather, that economic growth is crucial to sustain progress in human development while the high economic returns to investment in health and education contribute to growth and the reduction of poverty.

This convergence of views reflects a broad consensus of opinion within the international development community on the importance of investing in people which has shaped much of the recent development debate. In particular, governments are now urged to increase their efforts in health and education and to protect the social sectors when overall government expenditures have to be cut back.

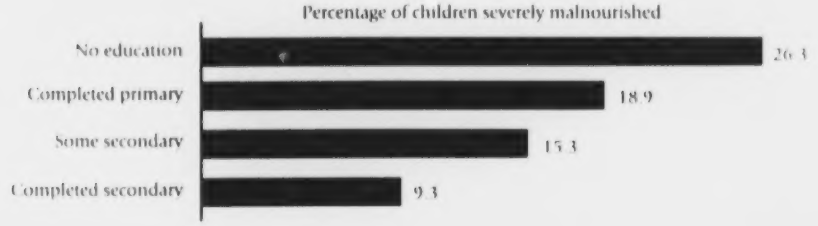
Growing Understanding of Human Capital Development

It is by now widely accepted that the human capital of a country is key to its economic and social development. Yet it was only three decades ago that the first economic studies emerged showing that expenditures on education are best regarded not as consumption but as an investment that enhances people's productivity.

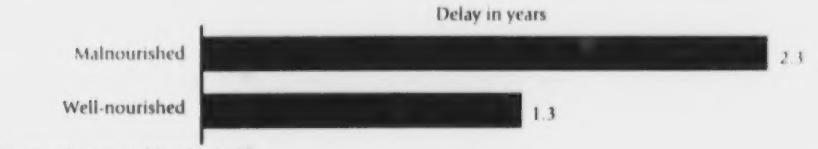
A large literature quantifying the effect of education on earnings shows that the economic returns to this investment compare favorably with more

Figure 2 Breaking the intergenerational transmission of poverty

Mother's education and malnutrition in Nigeria



Nutritional status and years of delay before enrollment in school in Ghana



Source: Glewwe and Jacoby 1995.

conventional forms of (nonhuman) capital formation. And the benefits of education go far beyond increased earnings. Educated parents have fewer children, invest more in their children's health and schooling, and are more efficient in adopting sound nutritional and hygienic practices (figure 2).

Educated adolescents have lower crime rates. Educated villagers are more prone to care for the environment. And an educated population in general is more adaptive to democratic government, can more easily take advantage of new developments in science and technology, and is more efficient in organizing itself so as to foster general prosperity—especially in an increasingly open and competitive world economy.

The insight that expenditures on health do not only alleviate suffering but are also an investment in human capital came even later. In the past two decades many studies have confirmed what is clear from common sense: healthier people are more productive, and healthier and better-nourished children are more likely to enroll in school on time, to have lower dropout rates, and to learn better.

Expansion of Government's Role

Since the first half of the century, governments in developing countries have shifted from being marginal players in social service provision to account for about 50 percent of health spending and an even larger share of education spending today. Reasons for this change were political, historical, social, or even accidental.

Arguments about the "public goods" nature of health and education have played an important role. Some of the benefits of medical services

and schooling accrue to the individuals who receive them, but other benefits are shared by society as a whole. Governments therefore strive to focus public sector spending on services that impart the greatest social benefits.

Good education and health services not only enhance a country's growth prospects, they can also lead to a more equitable distribution of income. Governments therefore often cite increasing equity—and the related objective of reducing poverty—as the reason for greater government involvement in social service provision.

Further, where families are not able to pay the fees that private service providers charge, governments have a responsibility to offer more affordable services. The International Conference on Primary Health Care in Alma Ata in 1979, which has influenced much of the debate on health policy, proclaimed health a "basic human right" and urged governments to take "responsibility for the health of their people." Following this conference, several governments adopted policies aimed at the public provision of "free" medical care for their entire population.

For whatever the reasons, the rapid growth of public sector involvement over the same period that extraordinary progress was achieved in health and education in developing countries naturally leads to the question of whether government action was a major cause of the progress. And if so, what, if anything, that implies about making wise public/private choices in the future. There is no question that government action was a major contributor. Countries that made the fastest progress had the most activist public efforts in education and health (for example, China and Cuba before the 1990s). However in almost all countries where social services are provided publicly on a large scale, the burden on public resources is crippling and the quality of services has suffered. Countries now face new challenges in different circumstances. A new set of public/private issues and options is emerging, involving changes on the margin—keyed to a different starting place than prevailed a generation or two ago. In short, the earlier experience with massive government intervention is important, but it is not the end of the story.

Historical Roots of Present Trends

The transition from limited to substantial role for government evolved differently for health and education.

Development of Modern Health Care Systems

The global spread of western health care is a by-product of the massive expansion of European influence from the sixteenth century onward. As they spanned the globe, Europeans took with them their own forms of health care, first for their own use (such as the Madras hospital opened in 1664 by the British East India Company) and later to provide health care

for critical groups of workers (such as soldiers in India or miners in Ghana).

The establishment of medical schools also helped the spread of western medical ideas. The first medical school in North America, established in 1765 in Philadelphia, was staffed by graduates from Edinburgh. In later years graduates from Philadelphia established medical schools in Bombay, Calcutta, Lima, and other cities around the world.

Missionaries were also active in health care in the colonies. From 1830, medical missionaries traveled to China from the West, in some places establishing rural medical services that presaged the "barefoot" health workers of the 1960s. Throughout the colonial world, missionaries established sanitation and other public health measures, clinics, hospitals, and medical schools. These private initiatives are the foundation for today's health systems throughout the developing world.

But for all these efforts, until recently, health care in developing countries was scarce. Most people went without medical attendance, and—given the state of medical knowledge until recent times—those that had access to medical facilities were likely to receive more care than cure. It was not until the first antibody—penicillin—was mass-produced after World War II that western medicine began to be beneficial to large groups of people. And only in the past fifty years has the incredibly rapid pace of more recent discoveries in medical sciences and technology begun to shape health care delivery systems for the masses (box 1).

Not surprisingly, the path that the developing world's health systems have followed is not unlike that followed earlier by European countries. Increased urbanization and industrialization led to the formation of labor groups (armed forces, civil servants, teachers, white-collar workers, blue-collar workers—generally in that order). These groups then either organized themselves to provide health insurance through "sickness funds" or pressed for publicly financed social insurance systems. Governments got involved by providing health insurance for their own workers, mandating insurance for other groups, or directly providing health care.

But if the pattern of development was similar across regions, the pace differed. By 1950, while sixteen Latin American countries had enacted laws to provide health insurance (and other social benefits) to selected groups of the population, only two African and four Asian countries had done so.

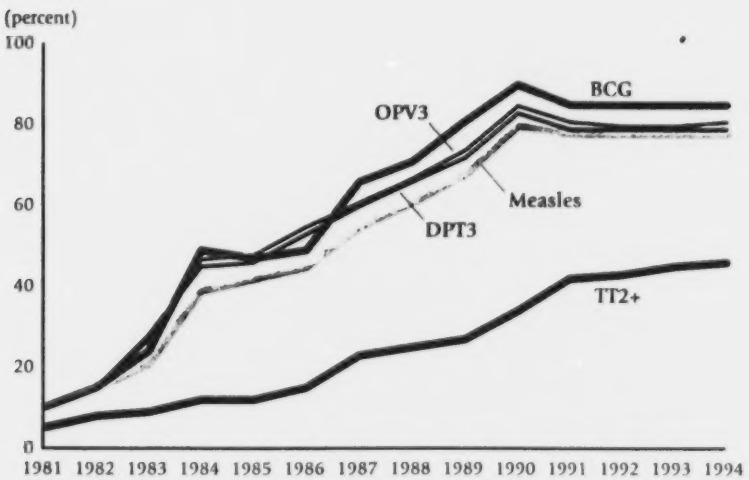
In subsequent decades, health insurance systems have expanded to cover an increasingly large percentage of the population but have met with varied success. Some developing countries, reflecting the spirit of the Alma Ata declarations, created national health systems that purport to provide free medical care to the entire population. But no system can ignore the binding constraint of limited resources even where health care is supposedly "free." Where some have tried, large groups of the population still lack access to basic services while others rely chiefly on private providers paid for from their own out-of-pocket expenses.

Box 1 A splendid public/private partnership—the expanded program on immunization

In May 1974 the World Health Organization (WHO) met to discuss the urgent need to immunize the world's children on a grand scale. Coverage in developing countries then averaged 5 percent and in some countries was nonexistent. It was estimated that a total of 5 to 10 million child deaths could be prevented every year by immunization against measles, poliomyelitis, diphtheria, pertussis, tuberculosis, and tetanus at a cost of about US$5 per child.

At that meeting the Expanded Program on Immunization (EPI) was born. It aimed for 80 percent coverage of all children under five by 1990. Between 1974 and 1984, preliminary work and infrastructure building was carried out by WHO. Since then—through intensive political commitment, training of health workers, social mobilization, and fundraising—EPI was launched within each of the world's developing countries. The results have been spectacular. By 1990 the EPI had reached its goal and 80 percent of all children were immunized against the common childhood diseases.

Immunization coverage, 1981–94



Source: World Health Organization data 1995.

Though EPI started as a WHO initiative, it soon included many multinational organizations. The actual work within countries was carried out by volunteers, private entrepreneurs, and government workers. World Rotarians alone raised more than US$240 million to provide polio vaccine to immunize some 100 million children a year, for five years, in 103 countries. They

Box 1 continues

Box 1, continued

also provided community-based leadership and resources for social mobilization efforts (such as transportation, logistical support, and communications and laboratory equipment for disease surveillance). In Nigeria, a national umbrella organization was formed to coordinate all nongovernmental support for immunization. In Peru, Rotarians were often the only means of reaching children in areas of guerrilla conflict. Private manufacturers have also participated in EPI, and because of economies of scale in vaccine production, manufacturers can provide large volumes of vaccine at a very low price to UNICEF's global distribution network and still make a profit.

This initiative was a spectacular success because it was a combined public, private, and multinational effort, with each organization using its comparative strength to fit each country's special circumstances. Building on the success of the EPI, the Children's Vaccine Initiative (CVI) was founded in September 1990, following the World Summit for Children. CVI will seek to harness modern science and technology to advance the development of new and improved vaccines for children. The founders of CVI include the UNDP, UNICEF, WHO, the Rockefeller Foundation, and the World Bank.

Development of Mass Education Systems

Today's modern education systems are also founded on private—often religious—initiatives. From the Koran schools in Indonesia and West Africa, to the Hindu gurus in India, to the Christian churches in most of Europe, to the village teachers of China, religious private schools have been teaching children the "three Rs" (reading, 'riting, and 'rithmatic) for centuries. In some cases their activities led to high literacy rates. One nineteenth century investigation of literacy in Canton, China, estimated that 80 to 90 percent of Cantonese men could read. In England during the 1860s—when education was not compulsory and was largely paid for by private fees—about two-thirds of the population was estimated to be literate.

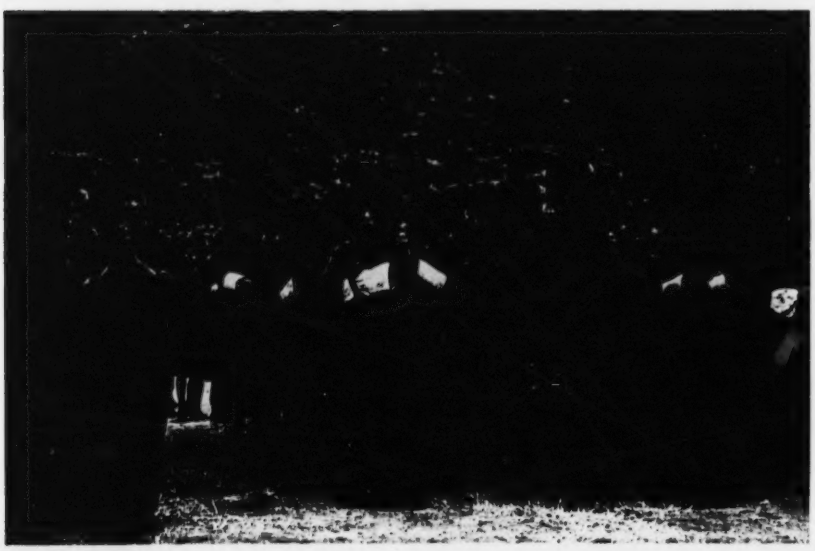
In general, though, education was a privilege of the elites. Mass education as we know it today is a nineteenth century invention originating in Europe and North America. Its most popular form, in which the government is responsible for providing free education for the entire population, became widespread in former colonies after independence. Expanding public sector enrollments were often accompanied by a reduction in the role of private schools. In Malawi, for example, the share of private primary schools as a percentage of total primary enrollment dropped from 77 percent in 1965 to 10 percent in 1979. In Benin during the same period, the share of private primary schools went from 40 to 4 percent and in Bolivia from 26 to 9 percent.

Yet the trend toward more public provision of education is not universal. Although in Colombia the share of private enrollment in secondary schools has dropped from 60 percent in 1960 to 40 percent today, private primary enrollment has increased to 15 percent. Enrollment in private universities and technological institutions, moreover, now represents 60 percent of the total. In Zimbabwe, the market for private skills training is expanding rapidly (box 2).

The private sector's share of Kenya's secondary education market has also grown substantially, going from 29 percent of the total during the late 1960s to 60 percent now. In Latin America, private university enrollment has increased from less than 3 percent of total enrollment in the 1930s to more than one-third today. And in Iran almost 40 percent of university students attend private institutions (box 3).

In some countries the growth in the supply of private sector schools and universities can be explained by the failure of the public sector to keep up with increasing or changing demand. Other countries have explicitly encouraged the private sector. The evidence is clear, however, that where public resources fail to keep up with increasing demand—especially for secondary and higher education—private schools enter to fill the gap.

Even where overall supply is sufficient, a perceived lack of quality in public institutions can trigger a private supply response, usually in the form of elite institutions affordable only for the rich. In Pakistan, for example, the government lifted its ban on private schools in 1979, and by 1983 more than 15 percent of total enrollment was in private schools. Part of this shift away from public schools no doubt resulted from perceived quality differences, but at the same time, total enrollment also increased. It is estimated that the shift to private schooling in Pakistan resulted in a 7 percent savings for the government budget without jeopardizing equity.



Box 2 Private sector takes a hand in programs for early childhood development

Research has shown that mental growth is most rapid before the age of five and that children not yet one year old are particularly susceptible to environmental influences. Inadequate nutrition before birth and in the first years of life can seriously interfere with brain development, leading to neurological and behavioral problems. Lack of stimulation and early stress, moreover, can lead to permanent losses in capacity. Without early outside help, therefore, many poor children face the prospect of being mentally or physically stunted, dropping out of school, and ending up a burden on the state.

Investment in early childhood programs promises high social returns. The US$1 million invested in the 1962 High/Scope Perry Preschool Program, for instance, yielded estimated returns equal to US$7.16 in higher productivity and avoided welfare costs.

Three decades of experimentation with early childhood development programs—both in the developed and developing world—have demonstrated that to work, such programs must fulfill children's mental and emotional need for interaction and stimulation, affection, and learning as well as their physical need for food, safety, and health care.

In many countries where governments fail to support such interventions the private sector has stepped in. Particularly prominent for are such private supporters of education programs as Holland's Bernard van Leer Foundation or the Geneva-based Aga Khan Foundation and such not-for-profit international NGOs as Save the Children, the Christian Children's Fund, and the Scandinavian-based Radda Barnen. Less prominent but no less important are the national NGOs, whose work within the community is supported either by their larger international counterparts or by the communities they serve.

Private business also supports early childhood development efforts, usually as a part of their philanthropic outreach program. This support can be indirect in the form of grants or direct, as in Mauritius's Export Processing Zones where both firms and employees contribute to support day-care for employees' children aged three months to three years.

As of December 1994, the World Bank had spent over US$745 million on projects integrating interventions in health and nutrition with other early child care services in the developing world. Because they span many sectors and must be carried out at many sites dispersed throughout the community, early childhood development projects require particularly close cooperation among central and local governments, NGOs, and community organizations.

More children than ever where in school, and some wealthier students opted to attend private schools.

Several East Asian countries rely heavily on the private sector to provide higher education and allocate the majority of their public expenditures on education to the more basic levels. The strategy of sponsoring broad-

Box 3 Public boost for private education—Islamic Azad University

Education has deep roots in Iranian history and culture. Following the government's recent push to make basic education universal, gross enrollment rates have increased to 110 percent at the primary level and about 44 percent at the secondary level. The enrollment of girls in particular, has increased significantly in recent years. Only higher education has been left behind.

In fiscal 1994, there were some 998,000 higher education students in Iran, just 18 percent of the cohort aged twenty to twenty-four. Public universities, which are tuition-free and operate under the Ministry of Higher Education and Culture, enrolled 61 per cent of the students. The remainder attended privately financed, tuition-paying institutions. More than 99 percent of these, moreover, study at the Islamic Azad University (IAU).

The Islamic Azad University is a privately funded nonprofit institution, the product of a remarkable experiment in the developing world. Founded in 1983 by the government, its achievements represent the fruits of a strategy aimed at expanding national higher education capacity with minimal additional state support. Initially the university benefited from land and building grants from the national and local governments, as well as from subsidized credit and access to preferential foreign exchange. Its recurrent costs, however, are covered almost exclusively from tuition fees.

While public policy and funding have resulted in noteworthy achievements in enrollment in Iran's lower educational levels, This private university has helped reduce the country's deficit in higher education capacity. Thanks in great part to the dramatic growth of IAU—both enrollments and branches—over the past twelve years—the national higher education enrollment rate went from 4 percent in 1982 to 18 percent 11 years later. In fiscal 1995, IAU enrollments numbered more than 400,000 students distributed among 118 branches throughout the country. The university is the largest institution of higher learning in the world today.

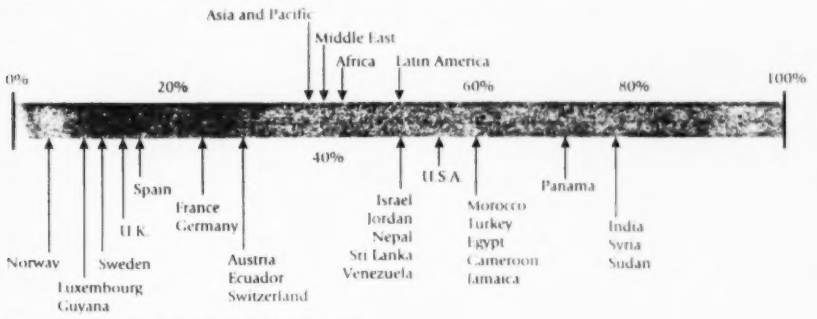
based public education at the primary and secondary levels while counting on the private sector to provide higher education has been identified as one of the pillars of East Asia's economic "miracle."

The Current Situation

Health

In the developing world today health systems generally reflect the organizational approach favored by the relevant colonial power. Much of Africa follows the English or French model, while Korea and the Philippines use the U.S. private provider-private insurance approach. In Latin America, large public direct-delivery systems operate alongside

Figure 3 Private health expenditures as a percentage of total



Source: Murray, Govindaraj, and Chellaraj 1994.

social security systems which sometimes hire private providers to deliver services. Other, more home-grown strategies are also in use. China's public hospitals are largely financed by user fees and insurance collections. But with its old rural health care delivery system largely dissolved (along with the agricultural cooperative that once financed and delivered care), a variety of private sector initiatives have arisen to meet the country's desperate need for rural services.

When government provision does not keep pace with public need as happened in China, the private health sector—both nonprofit and for-profit—expands (figure 3). In Malaysia, for example, the proportion of physicians in private practice rose from 43 percent in 1975 to 70 percent in 1990. In Indonesia about half of all hospitals are private. In Bangladesh 60 percent of qualified physicians were in the private sector in 1986, and today only 15 percent of the sick seek outpatient care from government facilities. In South Africa 59 percent of all physicians are in private practice; in Zimbabwe that figure is 66 percent. In Thailand the share of beds in private hospitals grew from 5.4 percent in 1970 to 13.7 percent in 1989. Even in countries with completely public health systems, it is not uncommon for patients to pay significant fees or "gratuities," either to public physicians who are legally moonlighting in private practices or as under-the-table payments.

Currently an estimated 50 percent of all global spending for health care comes from the private sector, although the amount varies considerably across countries and regions (table 1). Private spending on health is lowest—an estimated 29 percent—in the formerly socialist economies, but recent developments in this part of the world suggest that the actual figure is much higher. Private health expenditure in most other regions varies roughly between 40 and 60 percent.

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Education

Countries today also run the gamut of the public-private continuum in education (figure 4). Some school systems are almost wholly public (only one percent of all primary schools in Algeria, Japan, and Kenya are pri-

Table 1 The distribution of health care spending between the public and private sectors, by region

Region	*Percentage of total health expenditures*	
	Public	*Private*
Established market economies	61	39
Middle East	57	43
Formerly socialist economies	71	29
India	22	78
China	59	41
Other Asia and the Pacific Islands	39	61
Latin America and the Caribbean	61	39
Sub-Saharan Africa	53	47

Source: Murray and others 1994.

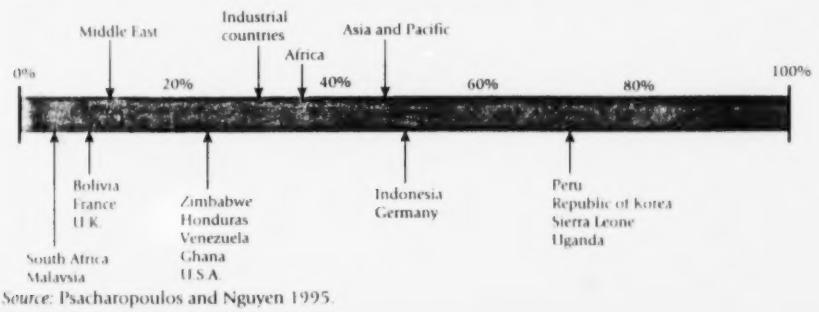
vate). More rarely, they are wholly private (all primary schools in Lesotho are private). The dispersion of private secondary schools is equally diverse. On average more than 20 percent of enrollment in secondary schools in industrialized countries is in private schools, ranging from 2 percent in Sweden to 62 percent in Belgium and 72 percent in the Netherlands. In Morocco private secondary enrollment is only 6 percent, while it is 45 percent in Argentina and 60 percent in Indonesia. In Latin America, one-third of all university students study at private universities; in the Philippines 85 percent of enrollment in higher education is in private institutions.

Worldwide an estimated 5.8 percent of GDP is spent on education, of which an estimated 70 percent is government spending and 30 percent private spending (table 2).

Explaining the Variance

What accounts for this diversity, both in education and in health? In some countries the public-private mix in education is a direct result of a political struggle to control the school curriculum. When the British authorities

Figure 4 Private education expenditures as a percentage of total



Source: Psacharopoulos and Nguyen 1995.

Table 2 The distribution of education spending between the public and private sectors, by region

Region	*Percentage of total expenditures*	
	Public	*Private*
Established market economies	70	39
Middle East	90	10
Asia and the Pacific Islands	53	47
Latin America and the Caribbean	43	47
Sub-Saharan Africa	66	34

Source: Psacharopoulos and Nguyen 1995

expanded education in the nineteenth century in India, for example, they declared English the official school language, but Christian missionaries taught in local languages in order to reach more of the population. In the Netherlands, a century-old religious split has resulted in a situation where almost two-thirds of all students today attend schools that are privately owned and operated but that are publicly funded.

In Brazil during the late 1960s and early 1970s, the military government kept a tight lid on public education spending despite a rapidly growing population. The resulting excess demand for schooling opened the way for private sector expansion. In Japan, too, where the premium on education is high and space in the best public institutions limited, more than a quarter of university students attend private institutions.

A comparative study using data from fifty countries shows that cultural heterogeneity, particularly religious heterogeneity, is the most important factor in explaining the variation across countries in private enrollment in primary school. But public spending and policies are also important (box 4).

The large difference in private sector size at the secondary level is almost completely due to differences in allocations of public spending on education. But if increasing resources for the public education system tends to crowd out existing private institutions, private sector expansion can also be discouraged by government policies that favor the public sector, such as not allowing public money to be spent in private institutions, excessive regulation, or—most drastically—prohibiting private schools outright. Conversely, private sector expansion in education can be invited by favorable public policies such as tax exemptions (as in the United States), direct subsidies (as in the Netherlands), or voucher systems (as in Chile).

The balance between public and private in the health sector is affected by similar pressures, although cultural or religious diversity is less of an issue. As in education, increased public involvement has been shown to crowd out private initiatives in health. A recent study of Medicaid, the health insurance program for the poor in the United States, for instance, estimated that between 50 and 70 percent of the increase in Medicaid coverage was associated with a reduction in private insurance coverage—an astonishingly large crowding out effect.

Box 4 Public-private partnerships: Option 1—public funding for private schools

Private school managers in the United States claim that—if given the same money accorded to public schools—they could teach students better and still realize a profit. In 1992, the Minnesota-based Education Alternatives, Inc. (EAI) received a contract to run schools in Baltimore, Maryland, and in 1994 won a similar contract with Hartford, Connecticut. EAI has pledged to quit if, after five years, its innovative teaching methods have not improved student performance.

Public funding for private schools is nothing new. In the Netherlands two-thirds of all students attend publicly funded private schools. When Chile reformed its education system in fiscal 1980, moreover, the Ministry of Education began providing per-student payments to both public and private schools. Because the payment was based on the average cost of education in the public sector and expenditures per student were 70 percent less in the private sector and private schools vied eagerly for students. By 1986, although primary enrollment in private schools had more than doubled, going from 14 to 29 percent, enrollment in private secondary schools increased almost four-fold.

By contrast, excess demand for—or rather, limited supply of—public health services has led to the proliferation of private providers in many countries. Poor quality of care provided in the public sector are another factor behind the growth of the private sector's share in health care. South Africa provides a particularly interesting example. As the economic position of black workers improved significantly during the 1980s, their trade unions became more powerful and real wages increased. Workers then began to demand access to better-quality health care, which was to be found in the private rather than the public sector. They also demanded that health care be paid for from private employer and employee contributions. From 1981 to 1991, the number of black African members in private insurance schemes tripled.

Comparing Different Options

What does the evidence say about whether a strongly public sector solution or a mainly private sector approach should be preferred? Mainly that many of the biases people hold, either for or against public or private sector-oriented strategies, are not correct. Equity, quality, and efficiency are not always better or worse when government is dominant, or when the private sector has the larger role. Reality is more subtle. The only reliable way to arrive at appropriate solutions is to rely on what has worked in the past and adjust it to meet the specifics of each new or changing situation.

To date, the best evidence on this issue is from comparative studies of

different approaches. And while good data are scarce, there is enough empirical information to challenge many conventional misconceptions.

Equity in Health

One recent study of health care systems in OECD countries concluded that—if equity is defined in terms of general health status—inequality is relatively great in Britain (with the most public of health care systems) and in the United States (with the most private of systems). Further, if equity is defined as equal treatment for equal need, a bias toward the rich shows up once more in the United States and the United Kingdom—but also in Spain, where health care is funded primarily from social security payments. On the basis of equity alone, therefore, none of the three major financing systems can be shown to have a significant comparative advantage.

Data from developing countries underscore a further point. Although many countries cite equity as the reason for strong government controls, public sector-controlled policies do not have a good track record on equity. In Indonesia, for example, the rich receive almost three times as much public health care as the poor. In China in the early 1980s, rural households—almost 80 percent of the population—received just 29 percent of public health spending. In Tanzania the richest fifth of the population use more than twice as many government hospital beds and more than four times as many outpatient services as the poorest fifth. In Côte d'Ivoire less than one-quarter of the rural poor who were sick received any form of medical care, as compared with half of the urban rich. In Peru only 20 percent of the poor received care, versus 57 percent of the rich. In general, when government expenditures are concentrated on urban areas and on hospitals rather than on basic services, the results are highly inequitable, governments are essentially subsidizing the rich (box 5).

Equity in Education

In education equity means equal access to good quality schooling. Most middle-income countries achieved near universal primary enrollment by 1985, but in low-income countries (excluding China and India) only slightly more than half of all six-to-eleven-year-olds were enrolled in school. By 1990 first-grade intake rates had risen to an average of 75 percent even for the least-developed countries, but of those enrolled, only 51 percent actually completed their primary education. In low-income countries, fewer than two-thirds of those who enroll in primary school complete the entire cycle.

Moreover, inequality in access and quality is often aggravated by government policies. In developing countries as a whole, 71 percent of school age children share only 22 percent of public resources, whereas 6 percent of students (that is, those who receive higher education) benefit from almost 40 percent of resources (figure 5).

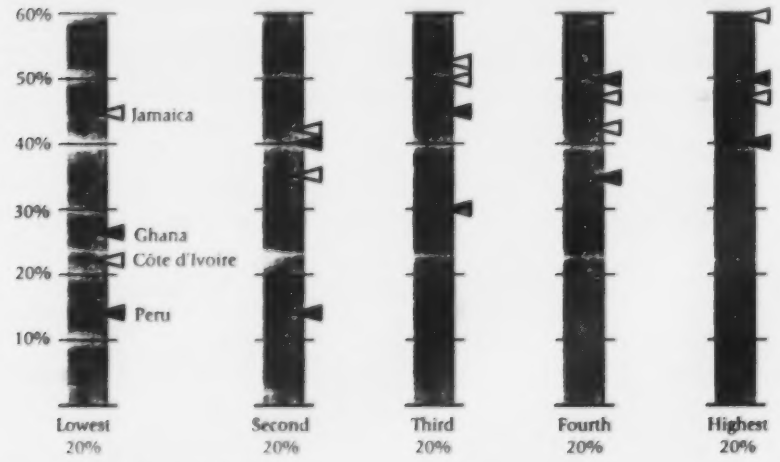
Geography and families' relative wealth also affect equity. Most of Brazil for example, has near-universal primary enrollment rates yet, a quarter of the children in the rural northeast, fail to enroll. In Colombia, enrollment in urban areas is 12 percent higher than in rural areas, but even within cities the rich are much more likely to be enrolled than the poor. In Viet Nam, where the rich can claim universal primary enrollment, one out of three poor children are not in school. Secondary enrollment in China is only 26 percent for the poorest quintile but 75 percent for the richest. These numbers are somewhat better in rural Philippines (43 percent enrollment for the poor versus 76 percent for the rich) but are worse in

Box 5 Unequal access to medical care

According to a recent comparative study of health care use in the developing world, large urban-rural differences in access and more use of medical facilities by higher income groups are typical patterns. These large differences persist, moreover, in the face of explicit government efforts to make access to medical care equal for all.

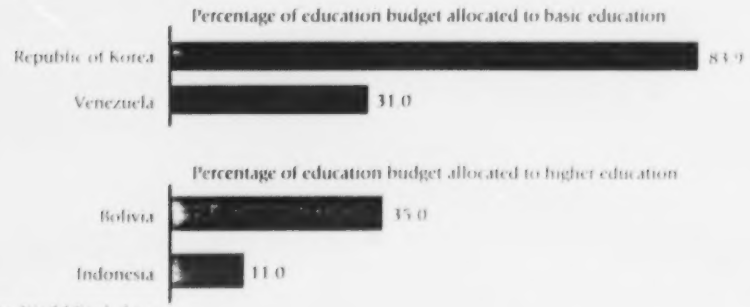
It is perhaps futile to strive for equality in very poor countries. Yet the health prospects of the poor could be greatly improved if public resources were used to increase access for the (mostly rural) poor and to support preventive medicine and basic curative care. Greater cost recovery for tertiary care would help finance such improvements, and allowing the private sector to provide services for those who could afford them would free up public resources, which could then be used to provide better access for the poor.

Percentage of rural people seeking care for illness or injury, by income quintiles



Source: Baker and van der Gaag 1993.

Figure 5 How countries divide up their education budget



Source: World Bank data.

Côte d'Ivoire (21 percent for the poor in the savannah area, 59 percent in urban areas). Inequalities are particularly marked where a high percentage of the public budget is allocated to higher education and private provision of education is discouraged (box 6).

Quality and Efficiency

It is often argued that allowing a larger role for the private sector will help improve quality and efficiency in the social sectors, even in public schools and health facilities. But critics warn that private providers—especially private for-profit providers—may reduce quality by reducing inputs (such as teaching materials) or keeping teachers' and doctors' salaries low. Critics also fear that private providers will try to increase their profits by providing services that are at best unnecessary, at worst harmful.

Brazil's excessively high rates of Caesarean sections (concentrated in low-risk, high-income groups) and flourishing markets for high-priced diploma mills (which provide virtually no education) for example, are hardly a strong endorsement for the private sector. But while such excesses obviously exist, it has also been shown that where the private sector works side by side with the public sector, the private sector usually out-performs the public sector in both quality and efficiency (box 7).

Numerous informal comparisons—which generally ignore vast differences in resource use and in case mix between public and private health facilities—virtually always favor the private sector. But the few controlled studies that do exist also seem to confirm the private sector's superiority in providing cost-effective social services in most cases.

A comparative study of residential childcare facilities in England and Wales, for example, found that similar services cost £41 to £52 more per child per week in public institutions than in voluntary or private children's homes. Both types of nonpublic institutions have apparently devised more efficient technologies for delivering care. Like its residential

child care facilities, Britain's private home-care facilities for the aged and infirm also provide good value for the money, having all the virtues of "Mom and Pop" enterprises: proprietors and their families are on call for long and flexible hours at wages that are usually lower than those paid in the public sector. A study of dentists in Finland found private dentists to be a whopping 56 percent more productive than their public counterparts.

In the United States, students educated in private schools (which, particularly when parochial, are attended by poor as well as rich students) consistently score better on standardized tests of verbal and mathematical skills than do their publicly educated counterparts (box 8). A recent study, moreover, found that competition from private schools significantly raised the quality of public schools, as measured by educational attainment and matriculation rates.

Evidence regarding the comparative performance of public and private schools in developing countries is scarce, but where those studies exist, private schools usually out-perform public ones. A study of schools in Thailand found that privately educated eighth graders scored higher in mathematics than did their publicly educated peers. In the Philippines, on the other hand, although private school students showed a 14 percent

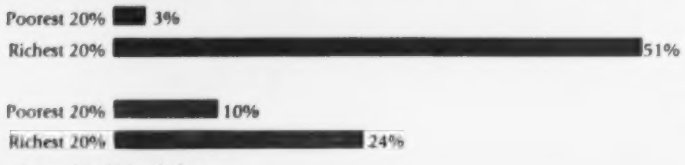
Box 6 Unequal subsidies for higher education

In the past many developing countries have used the lion's share of their education budget to subsidize university tuition and teaching materials. In some countries, university students even receive living allowances that exceed the per capita income. Yet subsidies for higher education benefit higher income groups far more than they benefit the poor.

Malaysia is an example of a country that has moved away from this inequitable pattern of education spending. National spending on higher education back in 1973 was estimated to benefit some 3 percent of the poorest of Malaysians and 51 percent of the richest. By 1989, these figures were a far more equitable 10 and 24 percent.

Malaysia could reduce the inequalities in its education spending still further by removing restrictions on private education. If students who could afford it chose to attend private schools, public transfers to the wealthy would be substantially reduced, which would lessen the burden on the public purse and free up funds that could be redirected to the poor.

Subsidies for higher education in Malaysia, by income group



Source: World Bank data.

Box 7 Public-private partnerships: Option 2—public schools, private management

In an experimental program in Bolivia, the government contracted the church-based Fe y Alegría to manage a certain number of public schools, mostly at the secondary level. Before agreeing to do so, Fe y Alegría demanded (and received) the right to appoint principals and teachers and to allow teachers to work both the morning and afternoon shifts—rather than the 3.5 hours allotted for instruction in public schools.

In all other ways, Fe y Alegría schools are identical to other Bolivian public schools. Although hand-picked, their teachers are ordinary normal-school graduates, who receive little special training and are paid the same salary as other public school teachers. Fe y Alegría schools receive no additional money for books or supplies, and their curriculums and teaching methods are the same as those used in the public schools.

The only comparative advantage Fe y Alegría schools can point to is an exceptional esprit de corps among students, parents, and staff. For both teachers and students flock to Fe y Alegría schools, despite their similarity to public schools, with many families paying extra school fees to attend them. On the rare occasions when innovative teaching methods have been tried (such as a math course transmitted over a public radio station), they have also proved very popular, both in the schools and throughout the community. This public-private partnership between government and a religiously-based nongovernment organization appears to be so successful that the government is studying it as a possible model for national education reform.

Box 8 Public-private partnerships: Option 3—providing parents with a choice

One solution to the problem of poor-quality schools that has been widely discussed in the United States is the school choice or voucher system. Under this system, individual students would be given vouchers funded by public tax dollars but redeemable in either private or public schools. Schools, would then have to compete for student patronage.

Opponents of the voucher system predicted it would lead to a mass exodus of public school students—particularly the better ones—that would gut the public system. Yet in a 1993 pilot school choice program in Puerto Rico, the 18 percent of participating children who did transfer to private schools was largely offset by another 15 percent, who actually transferred from the private into public system—hardly the mass exodus predicted. The Puerto Rican experiment was so successful, moreover, that by its second year the number of applicants had jumped from 1,600 to 15,500.

advantage in English achievement scores, public school students did somewhat better (4 percent) in math.

A comparison of public and private schools in Colombia and Tanzania found higher academic but lower vocational achievement in private schools. A Brazilian study found higher achievement in mathematics in private schools. In the Dominican Republic's two-tier fee-charging private school system, the more elitist schools proved to be surprisingly inefficient: costs were 46 percent higher than in public schools but achievement than public schools was 20 percent lower. The Dominican Republic's non-elitist private schools, on the other hand, proved remarkably efficient, producing 10 percent higher achievement than public schools at 60 percent of the cost.

The Role of the World Bank

In March 1995 at the World Summit for Social Development in Copenhagen, the international community committed itself to renewed efforts to eliminate the social deficit and reduce poverty worldwide. These efforts will take place in a world that has gone through major political and economic changes in the past few decades, and the situation is likely to be vastly different again at the dawn of the twenty-first century, presenting new challenges and calling for innovative solutions.

But after more than a half-century of experiments with alternative forms of economic development, the evidence strongly favors the proposition that competitive markets are the best and most efficient way yet known to organize the production and distribution of goods and services (World Bank 1991b). Consensus is also forming that a market-oriented approach to development—complemented by a transparent legal and regulatory framework and government that steps in only where markets fail—can yield spectacular results. As a consequence governments all over the world are redefining their roles. Once owners of state enterprises and producers of goods and services, they now seek rather to provide the environment in which private enterprise can flourish and civil society thrive. Complementary to this market-oriented approach are policies that allow the population—especially the poor—to take full advantage of opportunities created by the market economy, such as investments in infrastructure, protection of the environment, and—most of all—investment in people.

Responding to the world's evolving understanding of what works best in development, the World Bank has dramatically increased its lending for health and education from 5 percent of the Bank's total lending in the early 1980s to 15 percent in 1994. The Bank is now the world's largest financier of social services, supplying US$2 billion a year for education, US$1 billion for health, and US$200 million for population activities. Over the next three years, moreover, new commitments are expected to reach a record US$15 billion (World Bank 1995a).

How can we make sure that these commitments, which complement the developing world's own efforts, will yield maximum benefits for the

world's poor? First, governments need to continue their efforts to keep distortions out of their domestic economy, for as comparative analyses show, human capital is rewarded more generously where market distortions are minimal. Second, in the social sectors as elsewhere, governments should focus on what they do best. In most cases that would include the provision of public goods and services. As this brief review has shown, many goods and services in health and education can be effectively provided by such private agents as NGOs, voluntary organizations, and for-profit institutions. Where that is the case, governments can often serve the needs of the poor most effectively by concentrating on regulation (to facilitate access and guarantee quality) and financing (box 9).

But eliminating the existing social deficit is not and has never been the responsibility of government alone. Indeed, government's large role in the social sectors is of relatively recent date. To promote private sector involvement, the World Bank in joint efforts with governments, is increasingly working with private providers of health and education services. The Bank is also firmly committed to increase its lending in health and education projects that focus on the needs of the poor. Its policies are based on general principles proven, during decades of development experience, to lead to a more equitable and efficient provision of high-quality social services (box 10). In the next section we present examples of how projects sponsored by the World Bank and designed with Bank help are allowing developing nations to turn these policies into action on the ground.

Box 9 The IFC in health and education

The International Finance Corporation (IFC) is a member of the World Bank Group. It was established in 1956 to encourage private sector activity in developing countries. It does this primarily through three types of activities: financing private sector projects, helping companies in the developing world to mobilize financing in the international financial markets, and providing advice and technical assistance to business and governments.

In recent years the IFC has approved loans for health care and, to a lesser extent, education projects. The projects include a private school in Kenya, private hospitals in Indonesia and Thailand, a diagnostic center in Nigeria, a drug distribution center in Côte d'Ivoire, and manufacturing of pharmaceuticals in Jordan, Portugal, Turkey, and Tunisia.

To be eligible for IFC financing, projects must be profitable for investors and benefit the economy of the host country. Clearly, such projects can be found in both the health and the education sector.

Box 10 Suggestions for attaining an optimal public-private mix

- Focus public efforts on what governments do best—providing public goods and services and a regulatory framework that ensures minimum standards of quality and prevents fraud.

  One often-overlooked public good is access to information regarding the quality and effectiveness of social service providers. Governments can help to empower users by providing such information on a regular basis.

- Strive to guarantee access to basic health and education services for all.

  Governments should not attempt to provide services but rather to ensure more equitable access to them through a combination of insurance schemes, voucher systems, subsidies, and tax credits that make at least basic services affordable to all.

- Price higher-level facilities realistically and reallocate public resources toward essential basic services.

  Although basic health and education services have the highest economic and social payoff, current public spending frequently favors higher-level facilities. This pattern needs to be reversed. More equitable access to higher education and hospitals can be facilitated by scholarship, school loan programs, and health insurance schemes.

- Facilitate a pluralistic system of supply.

  When users are empowered with information and resources, they need several providers to choose among. Where private providers compete with public ones, consumers have this choice. Furthermore, competition will increase overall quality and efficiency.

PART 2

Examples of World Bank assistance

Reports from the field

1. Kenya's Training of Small-Scale Entrepreneurs

Most workers in Kenya find employment in the informal sector. Recognizing this, the government is now turning to the private sector to offer training in entrepreneurial and technical skills. A Bank-financed project supports the use of individual training vouchers and contracts for private educational institutions to create a competitive training environment that responds flexibly to the changing skill needs of small-scale entrepreneurs.

Every year Kenya must absorb almost 500,000 new entrants into the labor market. But for this to happen, employment in the formal sector would have to increase by 17 percent a year—a far cry from the actual average annual growth rate of 3.6 percent over the past decade. Therefore, for the foreseeable future at least, most new entrants will end up working in the informal sector.

Luckily Kenya's informal sector is large and dynamic. But although it contains 95 percent of all entrepreneurial and technological businesses in the country and accounts for 37 percent of total urban employment, the level of skills in the sector is low. The government of Kenya has therefore established a Ministry of Technical Training and Applied Technology (MTTAT) and charged it with developing training programs for the informal sector.

Previously, the public programs that provided the vast majority of technical training in Kenya failed to train people in how to develop their own businesses or to find employment in the informal sector. Public training programs are also generally too inflexible to provide the variety of skills needed in a changing market. With World Bank support, the government is now turning to the private sector to help advance workers' knowledge and improve their technological and entrepreneurial skills.

Over the long term, the Micro- and Small Enterprise Training and Technology Project will enhance private sector development and remove obstacles to increased employment and profitmaking in the informal sector. The project targets manufacturing enterprises with one to fifty workers, in major urban and periurban areas and offers incentives to help increase women's representation in traditionally male environments.

Box 11 The corporate world as a partner in education and health

In the 1980s, the corporate world joined the public sector and the NGOs as partners in the delivery of health and education services throughout the world. This was a new role for corporations whose previous involvement in these sectors had essentially focused on taking care of their own staff, or on selling goods and services to the providers, and on philanthropic contributions to these systems. A number of public/corporate partnerships have matured from the experiment phase into wide-scale programs. Although many of these initiatives have not benefited from structured evaluation, they should not be set aside as unproven or unquantifiable successes: the four examples below show what such public/corporate alliances can offer developing countries in resources, skills and access.

PanAmSat: its Global Satellite System provides—often free of charge or at nominal price—international and regional tele-education and tele-medicine networks in remote or underserved regions of the world. Examples:

- The Government of Peru is using PanAmSat's transponder to provide educational programming to schools and universities across the country;
- Internet for LatinAmerica: through PanAmSat, the region's science foundations,universities and hospitals have access to international databases and e-mail connections to their US and international counterparts;
- Telemedicine: once a year, PanAmSat links physicians across Latin America with their counterparts at Miami Children's hospital to a technical and educational teleconference.

American Express Travel and Tourism Academy: this project introduces high school students in Brazil, Hong Kong, Hungary, Mexico, the United Kingdom, the United States, and soon Russia, to the tourism and travel

Box 11 continues

Under the project, the Micro- and Small Enterprise Training Fund was established to support training through a combined voucher and contract training scheme. The voucher program enables informal-sector workers to purchase the training they want, thereby introducing consumer choice. The contract scheme encourages both public and private educational institutions to make sure the training they provide is both competitive in price and relevant to market needs. Similar approaches have been used effectively in other countries—notably in the Philippines and Singapore.

The Training Fund also supports a voucher program to pay for short-term courses to upgrade skills and enterprise-based training for artisans and entrepreneurs. Beneficiaries select the training services they need in specific technical areas (such as business management, product design and diversification, marketing, standards application and adaptation, subcontracting, and the choice and use of appropriate technologies). The program aims to distribute 6,000 vouchers a year at a unit cost per voucher of US$150 (for management training) or US$200 for (technical skills

Box 11, continued

industry, (to facilitate recruitement), using local AmEx managers as catalysts to invite industry partners to participate in providing input, funds, classroom materials, teacher training, work experience opportunities.

In Jamaica, the **Business Partners for Education** (a group of private sector businesses and individuals providing funding and advocacy for educational improvement) has joined forces with the government and the education community to promote the use of technology in public schools. Together, they have first established computer laboratories in secondary schools, later providing computer-assisted instruction to improve literacy and numeracy. They have purchased equipment, and software, and they have trained teachers, conducted workshops and promoted the use of technology in education in their public informaltion campaigns. The Business Partners have also helped mobilized a US$1million grant from the Inter-American Development Bank for further work.

In Colombia, **British Petroleum**, in partnership with the central government (and in association with a World Bank-sponsored project) is setting up pilot projects in the municipalities of Aguazul, Taurmena, and Yopal, to establish integrated family care centers. British Petroleum is concerned about the social implications of its new large-scale oil exploitations in various parts of Colombia, while the government's interest stems from its recent decentralization policies that put responsibility for health and education in the hands of municipalities. The centers will provide traditional services (community homes, schools feeding programs), as well as new ones, including youth care, assistance to micro-entrepreneurs, and care for the elderly.

upgrading). These vouchers, which can be used at either public or private institutions and enterprises, give clients the purchasing power to select the educational provider of their choice. Highly efficient, the voucher approach to skills-upgrading also helps to prevent an oversupply of any single type of training. Training subprojects that enhance particularly in skill areas where women are presently underrepresented, are also eligible for funding under the project.

To help pay for the program and to make sure the services it provides are of value to recipients, beneficiaries are expected to pay minimal training fees. These fees will adjust to fit demand as information about the cost and outcome of skills training becomes more widely available. The marketplace will then hold training institutions accountable for price relevance and the quality of services they provide.

2. Private Girls' Schools Help Close Pakistan's Education Gender Gap

In Balochistan, one of Pakistan's poorest provinces, female primary school enrollments stand at just 15 percent. This means that only 83,000 Balochistani girls go to elementary school as compared to 324,000 Balochistani boys. To close the education gender gap, Balochistan has instituted the Bank-supported Primary Education Program—a model partnership between the public and private sectors that helps parents in poor villages and city slums to set up much-needed girls' schools.

In Country Villages

Under Balochistan's Primary Education Program, government supports the efforts of local nongovernmental organizations to organize parents and community leaders into village education committees. Once organized these committees are trained and given the resources to set up and monitor girls' schools in their own villages. While government agrees to build the schools and pay teacher salaries, parent committees are responsible for choosing teachers; overseeing enrollment, attendance, and the quality of education; and maintaining school buildings.

In just three years village committees have founded 198 new schools (before the program the grand total of schools in the province was 625), which now serve 8,420 female primary students. They also reopened forty-three schools that had been closed for lack of female teachers. Communities with new girls' schools report nearly full attendance by both teachers and students, and average female enrollments have reached 87 percent. (In three villages, female enrollment is 100 percent).

To deal with the acute shortage of qualified female teachers willing to teach in (and acceptable to) isolated villages, Balochistan has relaxed its requirement that teachers have a secondary school diploma. Potential teachers are recruited locally by the village education committee and asked to teach without pay for three months to demonstrate their dedication. They are then trained for three months by female master trainers, who travel around to trainees' home villages in mobile training units.

Box 12 Education equity for girls: Using monetary incentives

A recent study confirmed that three-quarters of Bangladeshi households with disposable income invest this income in their sons. To help keep girls in school as well as boys, the Bangladesh government is now offering monetary stipends to cover a share of the personal and tuition costs associated with education. Girl students receiving a stipend and their parents must sign an agreement committing the student to minimum days of attendance and grade averages on the yearly exam. Girls must also agree to remain unmarried through the grade 10 terminal examination. The educational stipends are paid into personal bank accounts opened for the girls in branches of commercial banks near their homes. As they get an education, recipients also learn how to manage money and gain a measure of economic independence Instituted in 59 subdistricts in 1994, this innovative program has now expanded to 118 subdistricts. The original aim of the program was to cover a quarter of the country and benefit some 1.3 million Bangladeshi girls.

The Bangladeshi government decided to fund the stipend program because of the clear societal gains (such as fewer and healthier children, more productive female workers) associated with higher education levels for women. Similar programs, such as the Female Education Scholarship Project, are estimated to have benefited more than 44,000 Bangladeshi girls since 1982. One such program, for instance, offered free tuition to girls in rural schools in grades 6 to 8, allowing many to stay in school who would otherwise have left.

Bangladesh's stipend program for girl students began with a social marketing program to make parents aware of its benefits. Its success was further assured by a compulsory primary education act, the establishment of new schools, and the inclusion of private religious schools in the project. In the program's first year, female secondary enrollment in the subdistricts involved rose 20 percent.

The girls' education stipend program proved so popular that the Bangladesh government has now expanded it into a national program. With the support of international donors, it will now serve 460 rural subdistricts and benefit some 5 million girls.

Some villages, unwilling to miss the chance of educating their daughters but unable to find village girls educated enough to become teachers, have elected to staff their new girls' school with a male teacher. Rather than wait the three years required to become eligible for government help, moreover, a number of communities have opted to build and furnish new girls' schools at their own expense.

In City Slums

Balochistan's Primary Education Program also aims to establish new schools in city slums. To date the program has set up twelve fellowship

schools in the city of Quetta, hired and trained fifty-three new teachers, and enrolled 1,500 girls and 500 boys. These high-quality, low-cost, private primary schools, moreover, were placed in squatter communities that had at least 200 to 300 eligible girls but no public girls' primary school.

Under the Primary Education Program, the city's Primary Education Directorate picks school sites, registers schools and monitors them for quality, and collects and analyzes data to support other evaluation efforts. The private Balochistan Education Foundation vets potential school operators, who are chosen from the private sector to run the new schools. It also trains both operators and parent groups in the areas of school planning, financial management, and monitoring. The foundation is responsible for auditing the books of new schools. Local NGOs help motivate neighborhoods to set up parent education committees, then work hand-in-hand with these committees to collect household data in the target area, prepare the initial proposal, maintain school buildings, and monitor enrollment and attendance.

Established parent education committees receive a grant from the program equal to 100 scholarships, which they can then use to hire a school operator. To help new schools through their first three years of operation, the program also subsidizes the hiring of one teacher and the recurrent costs for twenty-five girl students aged five to eight. Parent committees are required to enroll at least 100 local girls in this age group no matter how many other children attend the school, and schools that have fewer than fifty qualifying students receive no subsidy. Since schools are expected to be financially independent after three years, the program requires them to set aside a portion of the subsidy as a cushion for their fourth year, when it will be discontinued.

To ensure quality education in the new schools, the program limits class size to fifty students. Urban teachers are required to have no less than a tenth-grade education and receive special training under the program at the beginning of the school year.

The success of the Quetta program has encouraged Balochistan to expand it. Four more schools are now proposed for Quetta in 1996, as well as sixteen schools in four additional cities.

3. Bolivia Moves from Crisis Management to Investment in the Future

In 1985 Bolivia established the world's first emergency social fund to help people who lose their jobs because of economic adjustment. The Emergency Social Fund was to finance employment-creating public works and social sector investments and attracted considerable support from outside donors and aid agencies. It proved so successful, in fact, that it became the model for Bolivia's Social Investment Fund, which was established in 1990 to finance long-term development of the country's social services and to deal with the more intransigent problem of endemic poverty. Like the Emergency Social Fund, the Social Investment Fund is supported by the World Bank and other international and bilateral development organizations.

In 1985 Bolivia—one of Latin America's poorest countries—turned its economy around with new fiscal and economic policies. At the same time it established the Emergency Social Fund to help displaced workers. The fund supported public works that generated new (if temporary) employment and at the same time improved services in education, nutrition, and health.

But while the new, stable Bolivia—with a 4.1 percent rise in its GDP in 1991 and a 3.8 percent rise in 1992—began to see moderate increases in real per capita income, more than half of Bolivian urbanites and an even higher percentage of country people are still officially classified as poor. Nearly a quarter of the population is illiterate, and the country's rate of infant deaths (96 per thousand live births in 1990) is comparable to Haiti's. An astonishing three-quarters of rural and a quarter of urban Bolivians have no access to clean water. Even fewer have access to sanitation services.

With social service problems too large for any government to handle alone, private providers—whether for- or nonprofit—have become increasingly active on the Bolivian scene. Private schools, for instance, now account for 17 percent of all primary-level and 22 percent of all secondary-level students in urban areas. NGO-run health centers serve a good fifth of the population, and for-profit centers serve another 5 percent. (Three-quarters of all Bolivians, therefore, still depend on public health clinics or receive no health care services at all.)

Most of the education, nutrition, and health projects supported by the Emergency Social Fund were designed and carried out by NGOs, community groups, and private entrepreneurs. Supported by the World Bank from the beginning, the fund attracted US$190.8 million from many donors by project's end in mid-1992. With this money it generated jobs and supported substantial expansion and improvement of Bolivia's social infrastructure, directly benefiting 1.7 million people.

Now, with the country's economy growing and stable, Bolivia's government is looking to the longer term. Because the Emergency Social Fund

Box 13 Latin America's high-return social investment funds

In order to help people who lost jobs or income in the shift to a market-driven economy, many countries in Latin America established funds specifically dedicated for social investment. These social investment funds (SIFs) later became the model for funds established to support more permanent investment in infrastructure and essential social services for the poor.

Social investment funds were effective financial mediators—linking government and donors with the poor they wished to serve—largely because they were allowed to operate with a high degree of autonomy. SIF managers and staff were drawn from the private sector and paid at private sector rates. Their support was not linked to the annual national budget cycle, and they were exempted from cumbersome procurement and disbursement procedures. Frequent audits ensured that SIF dealings were above-board and financially sound, and computerized information systems further contributed to their efficacy.

But perhaps the major reason for the funds' success was their policy of working in close cooperation with the communities served. Because they were politically neutral, for instance, SIFs were able to develop positive working relationships with NGOs, who helped them carry out many social assistance and small-credit projects. The private contractors and workers hired locally, moreover, completed the SIF-supported infrastructure works which helped their own communities rapidly and efficiently.

The following Latin American social investment funds have received financial support from the World Bank:

Country	Fund	*Year of support*	*World Bank amount (US$ millions)*
Bolivia	Emergency Social Fund	1987, 1988	10, 25
Ecuador	Emergency Social Investment Fund	1994	30
Guatemala	Social Investment Fund	1993	20
Guyana	Social Impact Amelioration Program	1992	10
Haiti	Economic and Social Assessment Fund	1991	11
Honduras	Social Investment Fund	1991, 1992	20, 10
Nicaragua	Emergency Social Investment Fund	1993	25
Peru	National Fund for Compensation and Social Development	1994	100

had channeled resources efficiently to various sectors, it was decided to establish a similar fund to support the activities of private agencies and coordinate them with those of line ministries in the areas of health, water supply, sanitation, and education. Since January 11, 1990, therefore, Bolivia's Social Investment Fund (SIF) has targeted Bolivia's neediest communities, complementing rather than replacing public social services. Like the Emergency Social Fund before it, the Social Investment Fund provides a convenient mechanism to mobilize external assistance.

To keep it flexible and responsive to local concerns, the Social Investment Fund primarily sponsors proposals identified and prepared by local communities. A third of the organizations asking for SIF financing are privately run, and small or medium-sized local contractors have been involved in all of the 1,473 subprojects approved as of December 1994. In addition, the SIF trains public and private institutions and local engineering and social service consultants to prepare and supervise projects.

While the Social Investment Fund is helping to develop Bolivia's private sector, it most affects the lives of poor people in remote rural areas, who have had virtually no access to social services. In many cases the Social Investment Fund has supported the efforts of NGOs and church-supported agencies to bring the first schools, health clinics, safe water, or sanitation services to an area. At the same time, it has created numerous local temporary jobs.

In April 1994, Bolivia passed the Popular Participation Law transferring both the resources and responsibility for soliciting and maintaining social investment to the municipalities. The Social Investment Fund is currently helping communities to deal with these new responsibilities in social service provision.

4. Home-grown Initiatives Bring Better Services to Mothers and Children in India's Slums

With one in three of its urban citizens living in abject poverty, India is seeking new and better ways to target women and children, who account for more than two-thirds of the urban poor. India's centrally controlled Family Welfare Program has made real gains over the past forty years. But programs recommended by the World Bank-supported Urban Slums Family Project, which invite local people to define local problems and use private individuals and organizations to provide needed services, promise even better results.

While India's population has more than doubled over the past fifty years, its urban population has nearly quadrupled. Over 200 million people now live in 3,600 Indian cities, one in three of them in abject poverty. This means that 70 million Indians live in unhygienic tenement houses, illegal squatter colonies, or even on pavements with no shelter at all. Every year another 15 million swell their ranks, and nearly 68 percent of these slum-dwellers are women or children.

Under its centrally controlled Family Welfare Program, India reduced the rate of infant deaths from 135 per thousand (in the early 1970s) to roughly 80 per thousand (in 1989) and the rate of fertility from almost 6 percent (in the 1960s) to 3.9 percent (in 1988). Yet—as Bank-supported family planning efforts in Bombay and Madras have shown—programs devised by communities and carried out in cooperation with private medical practitioners (both allopathic and traditional) and local medical associations can be even more effective.

The five-year, Bank-supported Urban Slums Family Welfare Project therefore proposes to enlist private organizations and medical practitioners to train (and supply with an essential medicine kit) some 21,000 urban health workers and local leaders. When each municipality was asked to assess its own needs for this project, moreover, Calcutta stipulated that three-quarters of its trainees be local women.

The Urban Slums Family Welfare Project will also promote community involvement by supporting supplementary health support schemes run by neighborhood committees (often in partnership with private voluntary organizations) in nutrition, sanitation, and health. To raise the

quality of family welfare services and make them more widely available, the project has made a concerted effort to secure the involvement of those private voluntary organizations with established ties in India's slum communities. It will also pay fees and offer free supplies and training to private medical practitioners working in slums.

Finally, to increase demand, the government has initiated a program to educate the populations of Bangalor, Calcutta, Delhi, and Hyderabad about the benefits and availability of family welfare services newly improved under the Urban Slums Family Welfare Project.

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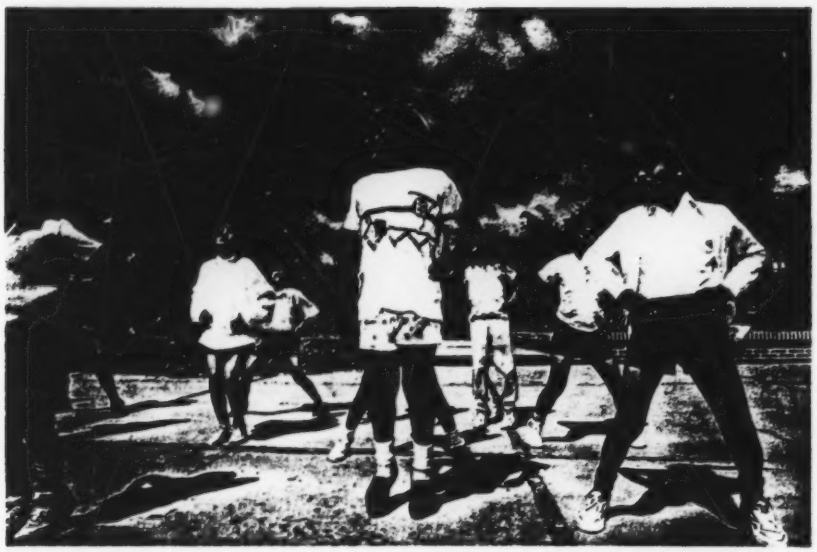
5. Does Colombia's Education Voucher System Work?

Colombia's cities are surrounded by poor, densely packed neighborhoods that lack even the most essential services. Few have a sufficient number of public secondary schools, and schools run by church groups or other private voluntary organizations have sprung up to fill the gap. To increase the educational opportunities open to its poorest children, Colombia's government has initiated a Bank-supported, short-term incentive program that grants individual student vouchers usable in private schools.

Although Colombia can now boast nearly universal primary education among its urban labor force, less than half of its children go on to acquire secondary schooling. This is in part the legacy of the country's meager investment in education—among the lowest per capita in Latin America in the 1970s and no more than 7.5 percent of GDP throughout the 1980s. Not surprisingly given this investment history, most public schools are now operating on two and even three shifts, and 40 percent of the country's secondary schools are privately owned and run.

In 1991—recognizing that the private sector would have to be part of the solution if the country was to solve its secondary education deficit—the government began granting vouchers (paid for jointly by the central and municipal governments) to poor students to attend private schools. The school voucher program is designed to create 546,000 new school places from 1991 to 1994 and to raise secondary school enrollment from 46 to 70 percent. To upgrade the quality of schools, the national government has also established incentives to commercial lenders (akin to guarantees offered for lending to small businesses) to encourage lending to finance improvements in private schools.

Under the secondary school voucher program, municipalities determine the number of vouchers they need and can afford to cosponsor. They also choose private schools to participate. Qualifying schools must have adequate health and educational facilities and be licensed by the Secretary of Education to grant the baccalaureate degree. Private schools are deemed to provide an adequate quality of education when their students' scores



on national exams are at least equal to those achieved by students in public schools.

In all the voucher program is designed to reach 45 percent of Colombia's school-age population. As of now, only eighty-seven schools have been chosen to participate, each in a municipality of at least 10,000 with at least three secondary schools. To receive vouchers, students must be fifteen or younger, come from the lowest two economic strata, and have graduated from elementary school. Distribution of the vouchers was weighted to the beginning of the program: 72,000 were distributed in 1992 and 25,000 were given out each year from 1993 to 1995. In 1993 the average voucher cost the government US$143.

Problems encountered so far include municipalities that have shirked their cofinancing responsibilities, thereby putting the future of the program in jeopardy. The problem of substitution—where vouchers merely allow students to shift schools rather than increasing overall enrollment—could be reduced or even eliminated by better targeting, such as granting vouchers specifically to fifth-graders identified as about to drop out. Vouchers ideally should be targeted to students too poor to attend school without them.

To determine whether or not vouchers increase overall school enrollment and influence the poorest people's education decisions, Colombia is studying two sample populations—one that received vouchers and one that did not. Affects on achievement will be determined by comparing grade-point averages, test scores, attendance records, juvenile delinquency rates, rates of transition to tertiary education, and rates of employment after leaving school. When the results of these studies are in, education policymakers from around the world should be able to draw valuable lessons from the Colombian experience.

6. Controlling AIDS in Burkina Faso

At the current rate of HIV prevalence in Burkina Faso, one out of every eight or nine citizens will be infected with the virus in just five years. The epidemic threatens to overwhelm the weak health care system of this poor African nation, and its economic consequences are incalculable. What can the government do? With Bank support, it has mounted a campaign to increase the use of modern contraceptives and change behaviors that spread sexually transmitted disease. In this effort, Burkina Faso needs all the help it can get from private health workers, pharmacists, and community and voluntary organizations.

Recent studies place Burkina Faso third among West African countries in prevalence of HIV infection in West Africa, following only Côte d'Ivoire and Ghana. In 1994—seeking to stem the tide of this devastating disease—the government initiated a Bank-supported campaign to change risky behaviors and extend the country's contraceptive distribution network.

At present private providers and nongovernmental organizations provide some family planning services in urban areas but none in the countryside. Under the project, government will provide supplies to distributors (both public and private) at a subsidized rate, launch a media campaign to promote sales of contraceptives, and teach traditional practitioners to refill contraceptive prescriptions, diagnose sexually transmitted disease, and refer cases to health clinics. The treatment of STDs will be handled mostly by NGOs, who will also train traditional practitioners.

In part to increase the demand for family planning services, the education campaign seeks to increase general understanding in the country of women's problems and rights. Surveys have shown that half of Burkina Faso's women, for instance, would like to space their children more than two years apart and almost a fifth want no further children. Clearly, there is sizable unmet demand for contraceptives in Burkina Faso. Under the governments program, massive supplies of subsidized condoms will be channeled through public clinics and NGOs and high-risk groups will receive condoms free.

It is recognized that—because the project will supply three-quarters of the estimated number of condoms needed—it will effectively suppress the private condom market. But a US$4 million fund has been established to provide grants to encourage private sector and NGO participation to expand mother and child health services, educate the public, distribute contraceptives locally, counsel people about STDs and HIV/AIDS, and offer AIDS patients community or home care. Project funds will go to cover local consultants, equipment, supplies, training, the use of mass media and other forms of communication, and essential operating expenses for local family services programs. Private entrepreneurs and voluntary organizations that mount subprojects are required to contribute 15 percent of counterpart funding.

7. Making Mexico's Workers Competitive in a World Economy

With Mexico now a member of NAFTA and the OECD, the government and the private sector have entered into a partnership to establish national occupational standards and train workers in an all-out effort to bring the country's work-force up to the international mark. The Bank is supporting this effort through the Technical Education and Training Modernization Project.

As part of the open economy established by NAFTA and the OECD, Mexico has a growing need for educated, skilled workers who can turn out products that meet international standards. As of now, however, the country has few technicians, many unskilled workers, and large labor imbalances in both supply and demand. Under the Bank-supported Technical Education and Training Modernization Project, Mexico's government will use the expertise of private business people to help establish a system of competency standards by which work skills and skills training programs can be tested and certified.

The project will also contract with both public and private educational institutions to train workers in the skills areas private employers identify as lacking. It will help training centers to redesign their programs on the basis of the new competency standards and to use modular units to make course offerings more flexible.

Mexico's National System of Competency Standards will be patterned after similar systems used in other OECD countries—in particular, the British system of National Vocational Qualifications. The Council for Normalization and Certification of Competency Standards will oversee the setting up of these standards, then delegate the authority to certify workers to chambers of industry and commerce, industrial and professional associations, and other private organizations.

Once the occupational standards are set, a publicity campaign will be targeted at apex-level employers, workers organizations, and sectoral chambers to spread news of them throughout the private sector. To further stimulate demand, pilot tests will be conducted in selected firms to demonstrate the efficacy of competency-based training courses and skills

certification. Finally, in a departure from past practice, Mexico will offer private industries financial incentives to train their own workers.

It is estimated that even in highly developed countries it takes at least ten to twenty years to put in place a new system of occupational standards and certification. By working with its private business to set standards for its industrial sector, train workers, and establish quality controls, Mexico has taken an important step toward making its economy the equal of its NAFTA and OECD partners.

Box 14 Zimbabwe's private skills training boom

With more than a million wage-earners, Zimbabwe has one of Africa's largest markets for skills training, and public training facilities alone cannot handle the growing demand. In 1986 for instance only a thousand applicants could be placed out of the 110,000 that applied for apprenticeships. Nor has government had the resources to pay the salaries needed to retain qualified instructors in technical colleges and polytechnics. The Zimbabwe Manpower Development Fund (ZIMDEF) rebate scheme to encourage employers to train their own workers has yet to function properly: in 1987 only seventy-seven firms received rebates, which covered the training of just 640 employees.

But if Zimbabwe's public skills training program is faltering, the private training market is vibrant and growing—driven by workers' increasingly high levels of general education. Stimulated by reimbursement of fees to individuals both from ZIMDEF and employers, correspondence colleges in Zimbabwe enroll approximately 200,000 persons every year, several thousand of whom go into technical, commercial and banking fields. Today in Zimbabwe, more than forty private colleges offer general, commercial, and technical courses during the day, while evening classes attract several thousand working students willing to pay for their instruction. The government Polytechnic has also entered the private market and now provides technical and engineering courses in the evenings for a fee. With 600 to 700 students at a time, these courses generate revenues sufficient to pay high salaries for well-qualified part-time instructors and still earn a profit of 20 percent. Venturing into the business of in-service training, Zimbabwe's colleges now offer intensive courses in specific business skills to more than a thousand persons employed in 350 firms. Private firms that also provide management training include training consulting and management firms, international accounting companies, and enterprises with excess training capacity.

8. Improving Health in Rural Panama

Although Panama has made great strides in providing its citizens with social services, not all of its citizens have benefited equally. In rural areas where health, water, and sanitation services are harder to deliver, social indicators remain at levels suited to a low-income country rather than to Panama, which is ranked as middle-income. Part of the problem is excess reliance on the public sector to the exclusion of individual, community, NGO, and other private sector initiatives—a policy the government's new approach to social development and the Bank-supported Rural Health Project aim to reverse.

Despite substantial economic gains made during the 1970s and early 1980s, almost a quarter of Panama's population today still lives in conditions of poverty. In the ten poorest districts—which account for about 15 percent of the country's total population—the average household earns less than US$850 a year; life expectancy at birth is ten years below the national average; and the infant mortality rate is three to four times the national average. In these same districts, a shocking 40 to 70 percent of children aged six to nine suffer from moderate to severe growth retardation caused by chronic malnutrition, and a third of all households have no access to clean water and basic sanitation. Despite Panama's sophisticated and costly public health system, moreover, 30 percent of the population do not have access to a health facility that could provide even a minimum package of primary care.

Past social sector development efforts have relied heavily on the central administration and the public sector, which does not have the logistical support systems needed to deliver social services. With the assistance of the World Bank, therefore, the Panamanian government has now initiated the Rural Health Project to seek out beneficiary and community organizations better situated than the government to deliver basic health and nutrition services and to construct water and sanitation infrastructure. Once facilities have been constructed, moreover, ownership of water and

sanitation infrastructure will be transferred to the beneficiary communities, who will then be fully responsible for their operation and maintenance.

The project will also support the training and equipping of about 1,500 community health workers (CHWs), a new category of personnel whose efficacy has been amply demonstrated in other small-scale programs. Community health workers will be trained and equipped to provide a limited range of primary health care services—including caring for newborn babies, vaccinating children, monitoring children's nutrition and growth, and distributing complementary food packages and micronutrient supplements.

CHWs will be trained by the Ministry of Health or by NGOs or other private sector agents with appropriate experience. As local health workers, they will be remunerated by the community they serve rather than by the Ministry of Health. It is expected that greater community involvement and more reliance on voluntary and other private organizations will help Panama bring the most essential services even to isolated rural citizens.

9. Reducing Poverty and Its Burdens, Peru-style

Peru's FONCODES is a prime example of a Bank-supported social investment fund that brings all parties—government, donors, NGOs, private enterprise, communities—together in a fruitful partnership to help the poor. Its mission is to funnel national, multilateral, and bilateral funds into small, labor-intensive projects that originate in and are carried out by local communities. FONCODES, supported by the World Bank and other development agencies, helps even the poorest neighborhoods to improve their skills and organizational abilities while working to raise their standard of living.

For many years Peru—with its high incidence of endemic poverty—has rated far below countries with similar GDPs in such poverty-affected areas as education, nutrition, and health. As it now stands, NGOs (led by the Catholic Church) contribute 36 percent of all support for rural development and microenterprises in Peru, 57 percent for basic education, 23 percent for basic health care, 10 percent for human rights, and 45 percent for all environment and social studies. Peru's government has therefore sought Bank support to increase its level of investment in the social sector.

In August 1991, Peru established the Fondo Nacional de Compensación y Desarrollo Social—FONCODES—to coordinate all social sector funds and more narrowly target them to the poor. FONCODES gives grants for small-scale, community-managed projects that improve social and economic infrastructure, provide direct social assistance, or generate income. The fund also depends on the 700 NGOs now estimated to be active in development in Peru to help communities identify and carry through projects. Finally, to make sure projects will be sustainable, beneficiary communities are required to contribute at least 9 percent of total project costs in cash, labor, or kind.

While municipalities are seen as the major managers of social programs in the future, they are presently too underfunded to handle larger programs alone. All across Peru, therefore, the executing committees of community organizations—"Glass of Milk" clubs where mothers distribute milk, community kitchens, neighborhood associations—have generated

12,000 grant proposals to FONCODES, about half of which have been carried out.

FONCODES social assistance programs include projects in health (primary health care, disease prevention, family planning, medical supplies) and education (preschooling, school supplies, school libraries, literacy campaigns, and the training of unemployed workers), which are deemed to have benefited more than twice as many people as development initiatives of any other type.

In one FONCODES-funded project, parent groups organized into associations representing at least 1,000 students proposed to take over responsibility for delivering school breakfasts for a year. After a local NGO defined the competitive bidding procedures, a local company was selected to provide the appropriate nutrition supplements. Under contract to FONCODES, the company now delivers supplies to the departmental capital, but it is the parents who pick up, check over, and authorize payment for the supplies and oversee the daily preparation and serving of the breakfasts.

Such community-based, public-private partnerships fostered by FONCODES have largely been a success. Many citizens have contributed time or worked at below-market wages to help the needy. Communities have formed close working relationships with promoters, inspectors, and FONCODES staff. Energized by their initial experience with this dynamic approach, many community groups are now submitting second and third proposals for FONCODES approval.

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10. Uruguay Seeks More Private, Less Public Health Provision

By any measure health care in Uruguay is good. Coverage is nearly universal, and provision is split between the public and private sectors. Yet public providers trail their private counterparts in quality and efficiency, and escalating costs and limited public funds threaten to widen the gap. To capitalize on private providers' comparative advantage and avoid developing a two-tier health care system that can offer only sub-par services to the poor, government is getting out of the provision business while strengthening its powers as watchdog over the quality of care. The World Bank's Health Sector Development Project supports these efforts.

Over the years Uruguay's tradition of social responsibility (dating back to the mutual-aid societies of the 1850s), welfare-state policies, and socially oriented private sector have combined to produce a comprehensive health care delivery system, that now covers over 90 percent of the population. To make sure that the quality of service remains high in the face of skyrocketing costs, the government has embarked on the Health Sector Development Project.

With Bank support, Uruguay aims to reduce healthcare's growing burden on the public purse by paring down government care-provider functions. At the same time, to ensure that high-quality services are available to the poor and uninsured, it will improve government health information systems and strengthen government powers of regulation and accreditation.

Uruguay's present health care system includes publicly funded and run health care facilities, private providers, insurers, and a variety of financiers. Care is financed through the public sector, the social security health insurance system (Dirección de los Seguros Sociales por Enfermedad—DISSE), the regulated not-for-profit sector (Institutos de Asistencia Médica Colectiva—IAMCs), and the private for-profit sector.

Presently, about 40 percent of the population (28 percent are uninsured) receives health care through the public sector. The Ministry of Public Health provides these services through some sixty hospitals, 200

health care centers, and—for tertiary care—the National Teaching Hospital.

But while public medical care is widely available, it is generally looked on as inferior to privately provided services. Salaries and staff have already

Box 15 Colombians turn to the private sector for family planning

In Colombia today half of all couples who use birth control and 60 percent of those using modern contraceptive methods obtain them through PROFAMILIA, a private family planning organization active in the country since 1965. Since 1965, moreover—when Colombian women bore, on average, 6.5 children each, and Colombia had the highest birth rate in the world—the national population growth rate has dropped 55 percent. Today 65 percent of couples of reproductive age practice family planning, and Colombian women average 2.9 children each.

This success in giving Colombians control over their own families' growth can be attributed at least in part to the government's continued openness on family planning and to the fact that the Catholic Church in Colombia has largely remained silent on the issue. But the chief architect of Colombia's family planning success is Dr. Fernando Tamayo, the private practitioner and founder of PROFAMILIA, who sought to make contraceptive services available to all women, rich or poor.

PROFAMILIA today has forty-eight clinics throughout the country and generates half of its own finances from reproductive health services (60 percent), selling contraceptives (25 percent), and other related sources (15 percent). Innovative and responsive, it was the first organization in Latin America to:

- Use radio to promote family planning.
- Offer voluntary sterilization services.
- Undertake the community-based distribution of contraceptives.
- Institute a contraceptive social marketing program.

In its effort to reach young people, PROFAMILIA has now opened seven Teenagers' Centers, which give personalized information about reproductive health to teenagers. These centers also produce informational radio ads and programs and provide students and teachers with videos, leaflets, handouts, and lectures on contraception, venereal disease, and sex education.

In addition to family planning, PROFAMILIA clinics offer a full range of reproductive health services and legal advice for such family problems as domestic violence or lack of child support. It continually polls customers to make sure their needs are being met, works closely with government, adds and redefines programs to target new groups, and carefully evaluates its efforts to make sure its leadership continues to be strong and effective. Throughout its history, PROFAMILIA has established numerous measurable objectives by which its success can be monitored and its future actions planned.

been cut in the public health sector, and infrastructure is deteriorating. With costs rising, moreover, the quality of public health services is likely continue to fall.

Most middle-class Uruguayans (more than half of the population) get health care through the country's fifty-three private medical, nonprofit cooperatives (IAMCs), which range from small groups run by the members to larger and more formal union-dominated arrangements. IAMCs are financed through transfers from the social security system. By contributing to the system, workers and employers buy individual health insurance as collective affiliations, and medical service providers negotiate monthly rates and co-payments (which are charged for all services except hospitalization) directly with the IAMCs. The Ministry of Public Health monitors IAMCs for quality, the Ministry of Finance for cost.

Uruguay's for-profit private sector offers partial insurance packages that supplement the standard health insurance available through the public sector and IAMCs. While still a relatively small share of the market, the number of these partial insurance schemes has grown substantially over the past five years.

Under the Health Sector Development Project, government will carry out pilot projects in four of the country's nineteen departments, contracting out responsibility for service provision to qualified private entities (in most cases, IAMCs). Other solutions under consideration are decentralizing services to local governments and establishing public hospitals as independent trusts.

11. Pakistan's Social Action Program Goes Local

Despite more than a decade of economic growth, Pakistan—with its centrally planned, government-run delivery systems and history of chronic underinvestment in social services—rates below countries with comparable economies in the areas of education, fertility, nutrition, and health. With Bank support, Pakistan has now embarked on the national Social Action Program that encourages individual communities to improve social services themselves, with the ultimate aim of bringing the country's social indicators into line with its high level of economic achievement.

Even after years of vigorous economic growth, Pakistan's average family is large, poorly educated, undernourished, and unhealthy. Female illiteracy is among the highest in the world, and health—particularly in urban areas—is poor. Although demand for contraception is high (surveys show that 40 percent of Pakistani women want to avoid pregnancy), family planning services are weak, and fertility is a striking 5.7 percent (as compared to 3.8 percent, the average for low-income countries as a group).

Projections suggest that returns on social investment in Pakistan, both social and economic, will almost certainly outstrip those on other types of investment. Yet with social services inadequate throughout the country, sector- or province-specific programs, which have attempted to deal with the problem piece-meal in the past, have largely failed.

Pakistan has therefore committed itself to increase national investment in the social services and to promote the ideal of smaller, healthier, better-educated families. Female education (which demonstrably lowers women's fertility and increases their—and their children's—productivity and health) is a particular Social Action Program priority.

Under the plan, Pakistan will decentralize the delivery of social services and clarify—province by province—the various responsibilities of each of the four social service agencies. It will also enter into annual agreements with private service providers, whose performance will be assessed on the basis of detailed operational plans and measurable targets. To facilitate a continual policy dialogue, coordination of effort, and joint monitoring initiatives, it

will set up communication mechanisms connecting communities, front-line ministries, departments, and the highest levels of government.

Perhaps the most innovative feature of Pakistan's Social Action Program is its emphasis on participatory development. Through nongovernmental organizations and other private institutions, it encourages local people to initiate projects to improve social services within their own community. The Participatory Development Program will give out US$10 million in grants to community organizations, NGOs, private institutions, foundations, academic and research institutions, and government agencies that come up with community-based cost recovery schemes or ways to deliver services that are better-suited to local needs. To build community responsibility, the program will also require locals to contribute to the support of essential services in their communities.

Earlier IDA-funded projects are already helping Pakistan's government to involve communities in efforts to improve rural water and sanitation and primary education. In addition a projected community-based family planning and health care project will seek to expand community-based family planning outreach and to train more community health workers.

It is estimated that some 10,000 NGOs now provide social services to communities throughout Pakistan. These organizations, which have established working relationships with local people, are excellently placed to identify projects and to organize, run, and mediate partnerships between small communities and the state.

There is now ample evidence to show that—whether publicly or privately financed—development cannot be sustained over the long term without community involvement. Significant local involvement, moreover, has great potential to make public programs more effective and the

use of public resources more efficient. It is estimated that some 2 million Pakistanis are now taking part in joint community-government efforts, yet some have questioned whether or not such efforts are replicable and affordable on a large scale. Pakistan's Participatory Development Program, which demonstrates how the private and public sectors can work together for the common good, may well point the way for the future of social service development.

12. Improving Health Care in Uganda Is a Private Matter

Life expectancy at birth in Uganda—whose people suffer under the double burden of a poor economy and inadequate health services—is only 47 years. In many areas where government services are lacking, private health providers, traditional healers, and NGOs have stepped in to fill the gap. For this reason, all of Uganda's current efforts to make health care effective and affordable require close cooperation with the private sector. The World Bank-funded District Health Services Pilot and Demonstration Project supports these efforts.

In Uganda one-fifth of all sick people go to a government health care facility; another fifth go to a facility run by a nongovernmental organization; and almost half go to traditional healers. As it now stands, therefore, a good 60 percent of Ugandans do not receive adequate, modern health care.

Uganda's government has therefore committed to increase public spending on health, aiming to ensure all citizens access to at least an essential package of health services. Under the Bank-funded District Health Services Pilot and Demonstration Project, moreover, it is experimenting with transforming public health facilities into self-governing trusts; contracting out health service provision; and instituting vouchers, insurance schemes, and other cost recovery mechanisms to make health services more sustainable.

Uganda is encouraging NGOs, for instance, to shift at least some of their efforts from cure to prevention. (Preventive measures are presently limited to childhood vaccinations funded under the Expanded Program for Immunization and Antenatal Care, largely paid for by patients.) The district health project will also support NGO health units, which offer basic health and reproductive services and carry out health activities in schools. To increase coverage and encourage private investment in the sector, the project will provide equipment for privately run facilities in underserved areas.

Another strategy that has been tested and proven in the international arena is transferring services once handled by the public sector to private providers. The district health project will fund studies to determine if it is

feasible to contract out Uganda's blood transfusion services and to identify which hospital-related services (such as catering, gardening, cleaning, laundry) could be provided better and cheaper by private agents.

Under the project, districts are also being encouraged to contract out to NGOs or other qualified private providers the in-service training for and management of health centers. The project, for instance, will hire a private training institution to offer new courses to health information clerks, and NGOs will be hired to manage district hospitals and health centers in two districts.

In smaller communities, the project supports experiments with new ways to pay for health services and expand coverage, such as the introduction of user charges and health cards. While pilots under the project are too small to affect health financing in Uganda as a whole, health financing methods such as these have shown considerable promise in other countries. Studies on insurance, prepayment schemes, and exemption mechanisms (such as vouchers) for the poor are also under way. Finally, Uganda's district health project will support workshops so that communities and districts can continue to exchange ideas and develop plans on the basis of experience for the wider and more efficient delivery of health care services.

13. Estonia's Brand New Private Sector Helps Modernize Health Care

Before 1991, Estonia's health system—like health systems in other former Soviet states—was totally public, highly centralized, and inefficient. While it provided curative services "free of charge," there was no mechanism for quality control, and modern family and public health services were not offered. Estonia has now asked the Bank to support its plan to make the country's health services—today available from a mixture of public and private providers—modern, affordable, and effective.

Estonia is at the forefront of formerly socialist economies in its commitment to health care reform. It has established an independent national health insurance scheme to reimburse competing public and private providers. It has reduced the number of hospital beds by 20 percent, cut the public's use of outpatient services, reduced admissions to medical school, and introduced modern public health concepts into the medical curriculum.

In some disciplines, private providers now challenge the public sector. Government policy, moreover, encourages both the private provision of care and private efforts to promote healthy behaviors and disease prevention, produce and distribute pharmaceuticals, and introduce quality control.

Promoting Healthy Behaviors

While mortality from infectious disease has declined in Estonia, little progress has been made with other key indicators. Deaths from cardiovascular disease, accidents, and injuries are still far more numerous in Estonia than in neighboring countries. The government has therefore launched a national health campaign to promote healthy behaviors and disease prevention. Supported by seatbelt and alcohol sales and consumption laws, this campaign includes vertical programs in smoking and accident prevention, heart disease, family planning, and communications management.

Estonia now devotes 5 percent of the revenues from its health insurance tax to the Health Promotion Fund, which awards small grants to set up community-based health promotion programs. The Ministry of Social Affairs is limited to no more than 40 percent of the total appropriation from this fund, and municipalities, schools, universities, health and voluntary organizations, and individuals may also compete for funds. Health promotion proposals are assessed and evaluated by a committee chaired by the head of the Public Health Department of the Ministry of Social Affairs and including representatives from the Ministry of Education, county doctors, and independent experts.

The first round of health promotion grants was awarded in April 1995. Of the grants, 21 percent went to the Ministry of Social Affairs, 28 percent to quasi-governmental organizations, 9 percent to local governments (including schools and day care centers), 14 percent to Estonia's only medical school, and 18 percent to the private sector. Grant recipients from the private sector included the Anti-AIDS Association, the Society of Nutritional Sciences, and a private family planning clinic.

Pharmaceuticals

Since independence Estonia's private sector has largely taken over the production and sale of drugs. Tallinn Chemical, the country's only pre-independence pharmaceutical plant, was privatized. Since 1992, moreover, three new, high-quality production units were established with the support of foreign capital. This increase in productive capacity has allowed Estonia to decrease its pharmaceuticals imports and still provide cheap, high-quality essential drugs for the local market.

Since independence, moreover, thirty-nine of Estonia's forty pharmaceutical wholesalers and 90 percent of its pharmacies have been privatized. The government regulates the price of pharmaceuticals by setting profit margins, which range from 5 to 25 percent for wholesale companies (depending on the base cost of the drug) and 15 to 80 percent for pharmacies.

Under Estonia's health insurance reform, all individuals are required to share the cost of outpatient prescription drugs. The amount of co-payment required depends upon whether or not the patient's illness and drugs are covered by the official package of essential services and drugs. Disabled patients, patients over seventy, and children under three pay only a nominal sum (equivalent to US$0.40) per prescription.

Before independence, Estonia set up the State Agency of Medicines as its drug regulatory authority. Today the SAM acts as a semiprivate agency, whose mandate is to register pharmaceuticals, control their quality and safety, regulate clinical trials, inspect manufacturers and sellers, issue import and export certificates, approve labels, and provide drug information to health professionals. The agency is fully supported by registration and other service fees.

Box 16 When market forces hit the health care system in the former eastern bloc

Health sectors throughout Eastern Europe must face up to a frightening fact: over the past three decades, mortality rates for men aged 45 to 60 have risen by 2 to 13 percent in the region while rates in Western Europe have fallen by 25 to 60 percent. In many countries, moreover, death rates are still rising Russia's 1993 crude death rates were an astonishing one-third higher than rates of three years before.

All plans to reform the region's public health sector clearly hinge on the state of the economy, but economic losses in recent years have been large. Russia's GDP dropped a disastrous 37 percent from 1987 to 1993, Poland's declined 10 percent, and Lithuania's 51 percent, and health indicators in these countries fell along with them. Economic loss also decimated both the national health insurance and the public's ability to pay for services out of pocket. Only in Poland and the Czech Republic—whose economies are beginning to rebound—do indicators suggest that the health sector is beginning to improve.

One tangible legacy of large, centrally controlled, supply-driven health systems is a massive health infrastructure. By 1990 the Czech Republic, for instance, had more hospital beds and doctors per capita than Germany and Austria combined. But while over 80 percent of Eastern Europe's doctors were specialists working for the government, the region spent on average only US$150 per person on health care—ten times less than was spent in Western Europe.

Since 1990 the market forces that are transforming the formerly socialist economies have also begun to transform their health care systems. Health services—medical and dental practices, pharmacies, and ambulatory diagnostic clinics—are going private in droves. Poland, for instance, had roughly 18,000 new private health-related businesses and 80,000 new health-care workers in the private sector (30,000 doctors, 8,000 pharmacists, and 9,000 dentists) by 1993.

Many countries have also transferred the responsibility for public hospitals from a central authority to local community control, and the privatization of the production, import, export, and distribution of drugs and medical equipment and supplies has been rapid. In 1990 Poland had 2,220 public and 1,737 private pharmacies; three years later only 587 of its 5,689 pharmacies were still public.

In a health care marketplace that gives consumers a choice, health care providers, governments, and enterprises have all become sensitive to price signals. Almost everywhere throughout the former socialist bloc, therefore, underused hospital wards have closed and health care staffs are being cut. Hungary, for instance, has plans to get rid of a fifth of its acute-care hospital beds.

Finally, governments in over ten formerly socialist countries have now introduced national health insurance programs complete with systems to track health information so that government's contractual arrangements with providers can be based on fact.

The Road to Self-Regulation

Estonia's reforms have separated financing from provision and introduced competition into the health market. With choice now possible, a new demand has arisen for information regarding the quality of the health care services available. Government licensing and accreditation regulations ensure that providers meet minimum standards, but the health insurance funds (which now purchase health services and are held accountable for their quality) are seeking more refined information on which to base their contracts with providers.

In 1993, Medaudit—a private, not-for-profit company that uses only health professionals of the highest credibility—began offering quality assurance consultancy services to Estonia's health insurance funds. One of their first studies revealed that treatment in four hospitals was delayed in 43 to 53 percent of pneumonia cases. In 12 to 50 percent of these cases, moreover, the hospital stay was too long and unnecessary diagnostic tests had been performed. The Medaudit study also showed that only 34 to 44 percent of patients with myocardial infarction had been hospitalized within six hours of onset, hospital stays were too long in 41 to 71 percent of cases, and indicated tests and treatments were routinely not used. It seems likely that—as demand from health funds and consumer groups for information on quality within the health sector grows—the private health consultancy industry is likely to grow with it.

14. Brazil's AIDS Program Brings NGOs into Center Focus

In three years the World Bank-funded Brazil AIDS and STD (sexually transmitted disease) Control Project should save 300,000 lives and US$1.2 billion. But—as Brazil's government has come to realize—public health services cannot achieve these goals alone. By having NGOs compete for AIDS project funding, the government has found a way to harness the private sector's energy and expertise in the battle to spread the word about AIDS and STD prevention. In addition, NGOs can often reach those neglected segments of society that shy away from more offical contact yet run the highest risk for infection with HIV.

Professional sex workers, IV-drug users, prisoners, street children—all of these groups on society's sidelines threaten to spread the epidemic of HIV infection ever deeper into the general population. Yet who is to help them, and how can they be reached?

AIDS programs all over the world are struggling with the problem of how best to inform masses of people—many of whom are inaccessible or illiterate—about the dangers of risky behaviors associated with sexually transmitted disease. Yet those most open to infection—prostitutes, IV-drug users, the very poor—are also the most difficult to reach. With its competition among NGO proposals for project support, the AIDS and STD Control Project has found a way that has worked so well that the project now supports 191 different NGO-designed-and-run AIDS and STD information, prevention, and service programs throughout Brazil.

Stirring Up Competition

Brazil requires all private, nonprofit organizations working in the country to register with the government. In 1993 when the AIDS Project competitions began, fewer than seventy registered NGOs were working in AIDS. After three years of the project, there were 432.

To make the most of this pool of community involvement and expertise committed to the control of AIDS, Brazil's government—working closely with World Bank staff—initiated an open competition for fund-

ing and put out the call to NGOs for AIDS project proposals. By the end of 1994, NGOs financed under this system were estimated to have distributed 2.6 million condoms and taken 11,000 calls to hotlines. Since 1993, a total of US$9.7 million has been granted to NGOs.

Yet for all its ultimate success, the NGO AIDS Project Competition went through its share of growing pains. When the procedure used to select the judges was questioned, the first round of the competition was scrapped to avoid any appearance of impropriety, and applicants were encouraged to reapply.

In the end Brazil was able to establish free and fair competitions open to all properly registered NGOs and judged by an autonomous and competent selection committee. The first essential step was to issue a formal decree establishing the selection committee and guaranteeing its independence from government control.

The present committee is made up of six unpaid judges drawn from four universities around the country. Judges were chosen for their experience in health education and demonstrated ability to evaluate projects in education and health care services. Although experience working with NGOs was clearly desirable, no representatives from NGOs were asked to serve on the committee, since their presence would automatically disqualify their sponsor organization from the competition.

The AIDS and STD Control Project's full-time NGO coordinator administers the competition. Grants are officially capped at US$100,000 and—with the exception of a few larger grants approved by the Bank—have ranged from US$13,000 to US$92,000, depending on the nature and scope of the project proposed.

Proposals are solicited and judged according to a set of published criteria, on the basis of which they are ranked into categories from A to C. Where two judges disagree about a ranking, a third is asked to rank the proposal blind. All proposals in the highest categories are funded automatically. Those ranked second are asked to make specific changes and then encouraged to reapply. The federal government notifies states and municipalities of the awards made.

Brazil has now completed four competitions to select projects dealing with HIV/AIDS that are designed and run by NGOs. The first round, held in 1993, financed seventy-five NGO-run projects for a total of US$4.1 million: eighteen for services for HIV-infected people, eighteen for the training of other trainers in the field, six for education, and thirty-three for efforts to discourage risky behavior. In the second and third rounds in 1994, eighty proposals were funded and US$3.7 million spent, the majority (thirty-seven projects) for education about the disease and its prevention. The fourth and last round to date was held in 1995. Although the committee elected to fund only thirty-six new projects, for a total of US$1.9 million, out of the 110 proposals submitted, it continued support for all projects approved in the earlier rounds. Sixteen other projects were funded through other project components such as IV-drug users, prisoners and street children.

During the first round it became clear that many of Brazil's NGOs needed help in preparing acceptable projects, budgets, and proposals. In a few cases where a proposed service was particularly needed (as when the Catholic Church proposed to undertake outreach, prevention, and counseling to street children), a consultant was sent out to help the NGO. Two general training courses on the subject of project design and proposal writing were also offered, one for NGOs in the north and one for those in the south.

NGOs who receive grants under the competition are also provided with a booklet on financial administration. To prevent any possible irregularities, all billings are sent to the federal government for review. Government-hired consultants visit NGOs in each city twice a year to monitor their financial transactions, and grantees are required to submit reports four times a year regarding their progress toward stated objectives. Perhaps because of this stringent approach to supervision, all but four of the 191 NGO-run projects financed under the four competitions have gone forward without a hitch.

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